COLORADO
Department of Health Care Policy & Financing

Responses to the ACC Request for Information

July 2015

Many thanks to the clients, family members, providers, advocates, and other stakeholders who responded to the Accountable Care Collaborative Request for Information (RFI). The Department received 121 written responses.

We received 3,945 pages of responses. The first RFI response contains the overview and appendix. All other responses contain only the Response Worksheet. Duplicate pages and blank pages of unanswered questions were removed from this document unless the file we received could not be modified.

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[1] In order to ensure that nothing that could be considered Protected Health Information (PHI) is released, all client responses were redacted by order of HCPF legal. Department staff reviewing RFI responses had access to the entire responses. All client responses were read and reviewed. Many themes from these responses have appeared in our public presentations on the RFI.

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Stakeholder Input

We will continue to seek stakeholder guidance and input through public meetings of the ACC Program Improvement Advisory Committee and its subcommittees. More information about the next iteration of the ACC Program is available via the RCCO RFP webpage, or by contacting Kevin Dunlevy-Wilson at RCCORFP@state.co.us or 303-866-5075.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 001

Accepted by: KJDW

Notes: Line breaks have been added post-acceptance

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

Table of Contents

SECTION 1.0 OVERVIEW

1.1. PURPOSE OF THIS REQUEST FOR INFORMATION (RFI)

1.1.1. The Colorado Department of Health Care Policy and Financing (Department) is issuing this Request for Information (RFI) to solicit input on the next phase of the Accountable Care Collaborative (ACC).

1.1.2. Information provided to the Department in response to this Request for Information will inform the Department's Request for Proposals (RFP) for the Regional Care Collaborative Organizations (RCCO) and the future design of the ACC Program.

1.1.3. Anyone interested in responding is welcome to submit a reply (persons or entities responding to this RFI are called "respondents" throughout this document). The Department encourages everyone with ideas about the ACC to respond.

1.2. DEPARTMENT BACKGROUND

1.2.1. The Department serves as the Medicaid Single State Agency, as defined by Code of Federal Regulations (CFR) Title 45 Section 205.100 (45 CFR §205.100). The Department develops and implements policy and financing for Medicaid and the Children's Health Insurance Program, called Child Health Plan Plus (CHP+) in Colorado, as well as a variety of other publicly funded health care programs for Colorado's low-income families, children, pregnant women, the elderly, and people with disabilities. For more information about the Department, visit www.Colorado.gov/HCPF.

1.3. PROGRAM BACKGROUND

1.3.1. The Accountable Care Collaborative (ACC) Program started in May 2011 with around 500 clients. Since that time, the ACC has grown in many ways. Today, the program covers over 700,000 people. The current phase of the ACC is focused on developing a strong network of contracted providers that can serve as medical homes for Medicaid clients. At the start of the program, enrollment was comprised largely of adults, and the pay-for-performance measures were designed for an adult population.

1.3.2. Over the course of the last three years, the ACC has expanded its focus from the medical home to the whole neighborhood of providers, such as specialists. Program enrollment expanded, increasing the number of children to mirror the overall Colorado Medicaid population. To continue developing the ACC, the Department updated pay-for-performance measures to include children and changed the payment model to support improved medical homes.

1.3.3. The ACC strives to provide the Colorado Medicaid program with a client and family-centered, whole-person approach that improves health outcomes and ensures savings. The program design includes a focus on clinically-effective and cost-effective utilization of services. The ACC works to identify the needs of clients and to use local resources to meet those needs.

1.3.4. The ACC was designed as a platform to transform the Colorado Medicaid program. The upcoming request for proposals (RFP) will build upon the successes of the current program by further developing the ACC to serve more people through greater efficiency and other incremental improvements. In addition to these updates to the program, this RFP will also seek to make bolder, more-comprehensive changes to the ACC through deeper integration, new payment reforms, and the promotion of whole-person/whole-family health.

1.3.5. These improvements will also be strengthened by significant investments in technology, as with the forthcoming Business Intelligence and Data Management (BIDM) system. These new platforms will allow for enhanced program monitoring and evaluation, and will give all parts of the ACC Program better data to improve care and decision-making.

1.3.6. As one of the major parts of the ACC, the RCCOs leverage local infrastructure, relationships, and community resources. The RCCOs' main responsibilities in the first RFP were:

1.3.6.1. Provider network development: developing a formal contracted network of primary care providers and an informal network of specialists and ancillary providers;

1.3.6.2. Care coordination: the RCCOs must ensure that every client has access to an appropriate level of medical management and care coordination;

1.3.6.3. Provider support: supporting providers in delivering efficient, high-quality care by offering clinical tools, client materials, administrative support, practice redesign, etc.; and

1.3.6.4. Accountability and reporting: the RCCOs are responsible for reporting to the Department on the region's progress, and meeting programmatic and Departmental goals.

1.3.7. The RCCOs are responsible for assisting clients with every aspect of their care. This means that they have to assist clients with their physical health and their behavioral health. The state pays providers directly for physical health services. In Colorado, Medicaid behavioral health services are managed by five Behavioral Health Organizations (BHOs) statewide. RCCOs frequently work with the BHOs to coordinate care. Almost all Medicaid clients are enrolled in a BHO when they receive Medicaid. The BHOs get a set amount of money to manage the care for Medicaid clients, and the BHOs reimburse their network of providers for delivering services to those clients. The five regions that the BHOs manage do not match the regions managed by the RCCOs.

1.3.8. Today, there are seven RCCOs, each working in a specific part of Colorado. Each RCCO has adopted a different approach that works in its region. The RCCOs and their leadership play a vital role in the ACC and offer customized and local health care experience to the program. The ACC leverages personal, human connections to build on the strengths of local and regional partners.

1.3.9. Just as the first RCCO RFP initiated the ACC Program in Colorado, this second RFP will launch the next iteration of the ACC. What the program looks like in the future depends upon the RFP, and the content of the RFP depends upon the insight and guidance you offer through opportunities such as this Request for Information.

1.3.10. **For more information on the ACC Program, click here**

1.4. VISION FOR THE NEXT RCCO RFP

1.4.1. The next phase of the ACC Program will build on the strengths and the lessons learned during the first iteration. There are three main goals of the next RFP. The Department welcomes input on these goals and how to achieve them.

1.4.1.1. 1. Transforming our system from a medical model to a health model.

1.4.1.1.1. A person's health is impacted by his or her social situation (for example housing, income, transportation, nutrition, presence of supportive family and friends) as well as medical care. The next phase of the ACC Program aims to promote health by developing systems that support healthy lives, rather than just medical care.

1.4.1.2. 2. Moving toward person-centered, integrated, and coordinated supports and services.

1.4.1.2.1. Person-centered care means that the individual/family/caregiver is an equal participant with the provider in defining health goals and developing treatment plans. These both must address the whole person and be achievable within the context of the person's life. To accomplish this, RCCOs must also be able to coordinate more-closely with non-medical services and other state agencies. In order to do this, RCCOs must understand the community and culture where the person lives.

1.4.1.2.2. Part of a whole-person or person-centered approach is addressing both a person's physical and behavioral health needs in a way that is coordinated and cohesive, often referred to as integration. Taking steps towards integration or better coordination of physical and behavioral health care for Medicaid clients is a primary goal of the next RFP. Behavioral health care refers to all services to treat health conditions that primarily present as alterations in thinking, mood or behavior and changes in emotional (mood), psychological (thinking), or social well-being (behavior) and conditions related to addictions. To create the infrastructure for this integration, the Department seeks input on whether or how the Behavioral Health Organization (BHO) or RCCO maps or functions should be adjusted so that they are aligned.

1.4.1.2.3. This next RFP will aim to continue to build on local strengths of each community. This RFP aims to be sensitive to the diverse needs of clients with Medicaid coverage and will develop specific expectations around meeting the unique needs of subpopulations such as children, adults, the elderly, persons with disabilities, clients involved in the criminal justice system, and all others.

1.4.1.2.4. Incorporating clients' perspectives is an ongoing process. The next RFP aims to strengthen opportunities for clients and advocates to provide input and play an important role in program design and ongoing improvement.

1.4.1.3. 3. Leveraging efficiencies to provide better quality care at lower costs to more people.

1.4.1.3.1. The next RFP aims to capture efficiencies and save money through enhanced technology and by supporting a diverse and changing health care workforce.

1.4.1.3.2. The RFP endeavors to align the financial drivers for all elements of the Medicaid delivery system. Through the RFP process, the Department will explore different ways to pay for care, bend the cost curve, and be as cost-effective as possible.

SECTION 2.0 ADMINISTRATIVE INFORMATION

2.1. RFI TERMS AND CONDITIONS

2.1.1. This RFI is issued solely for information and planning purposes and does not constitute a solicitation. Information about costs and pricing is submitted voluntarily and is non-binding on the respondent. Responses to this RFI will not be considered legal offers nor will they result in an award of any type of contract.

2.1.2. The Department is not responsible for any costs incurred by any respondents for the development and provision of a response to this RFI.

2.1.3. The Department is subject to strict accountability and reporting requirements as a recipient of funds from public sources. Responses to this RFI are subject to disclosure by the Department as required by the Colorado Open Records Act (CORA). The Department plans to make responses to this RFI available for review online.

2.1.4. The Department reserves the right to copy any information provided by respondents for the purposes of facilitating the Department’s review of / use of the information.

2.1.5. The Department reserves the right to use information or ideas that are provided by respondents. By submitting information in response to this RFI, the entity or individual represents that such copying or use of information will not violate any copyrights, licenses, or other agreements with respect to information submitted.

2.1.5.1. The responses received from this RFI may be used for the development of a future solicitation. Should a solicitation be issued, further details on the solicitation process will be provided.

2.2. POINT OF CONTACT

2.2.1. The Department's point of contact for this RFI is:

2.2.1.1. Kevin Dunlevy-Wilson (note: other Department staff may address e-mails or phone calls)

2.2.1.2. Department of Health Care Policy and Financing

2.2.1.3. Accountable Care Collaborative Strategy Unit

2.2.1.4. 1570 Grant Street

2.2.1.5. Denver, CO 80203-1818

2.2.1.6. Phone: 303-866-5351

2.2.1.7. RCCORFP@state.co.us

2.3. NOTICES AND COMMUNICATIONS

2.3.1. Communication with respondents will be via various methods including, but not limited to, e-mail, phone, mail, the Department's ACC RFP Web site at: https://www.colorado.gov/pacific/hcpf/regional-care-collaborative-organizations-rccos-request-proposals-rfp and notices on the CORE Web site at: https://codpa-vss.hostams.com/webapp/PRDVSS1X1/AltSelfService;jsessionid=00007DX5IavpsnQoNcRwuPiYmie:189n1q4b1. Respondents can view information posted on CORE by clicking on the "Public Access" button. It is the respondent's responsibility to periodically check the Colorado CORE Web site or the ACC RFP Web site for notices, changes, additional documents or amendments that pertain to this RFI.

2.4. TIMELINE

2.4.1. The timeline for this RFI is as follows:

ACTIVITY	DATE
RFI RELEASE DATE	OCTOBER 21, 2014
INQUIRIES REGARDING THE RFI ACCEPTED UNTIL	OCTOBER 31, 2014 11:00 AM MOUNTAIN TIME
DEPARTMENT RESPONSES TO RFI INQUIRIES (ESTIMATED)	NOVEMBER 10, 2014
RFI RESPONSE SUBMISSION DUE DATE	NOVEMBER 24, 2014 3:00 PM MOUNTAIN TIME

SECTION 3.0 RESPONSES

3.1. INQUIRIES

3.1.1. For inquiries about this RFI, you may send an email to: RCCORFP@state.co.us. If preferred, you may also contact the ACC RFP team by phone at: 303-866-5351. Include the RFI number and title listed in the e-mail subject line.

3.1.1.1. The Department will track the questions that it receives and aggregate the questions into an "Inquiries and Answers" document.

3.1.2. Inquiries received by the Department by the Inquiry Deadline will be responded to by the Department via a posting of the "Inquiries and Answers" document on the CORE Web site and the ACC RFP Web site. Inquiries received after the Inquiry Deadline may not be included in the Department's response.

3.2. PROTECTED HEALTH INFORMATION

3.2.1. Do not include Protected Health Information (PHI) in your response.

3.2.2. If the Department discloses the responses online or via a CORA request, unless the responder explicitly requested otherwise, responses by all Medicaid clients will be identified only by first initial and county of residence. Example: John Doe would be listed as: "'J.' Weld County." Requests for pseudonyms will generally be granted if requested.

3.3. RESPONSE FORMAT

3.3.1. The RFI is broken into the following sections:

3.3.1.1. Basic information about you, the respondent.

3.3.1.2. General Questions

3.3.1.3. Behavioral Health Integration

3.3.1.4. Care Coordination

3.3.1.5. Program Structure

3.3.1.6. Stakeholder Engagement

3.3.1.7. Network Adequacy and Creating a Comprehensive System of Care

3.3.1.8. Practice Support

3.3.1.9. Payment Structure and Quality Monitoring

3.3.1.10. Health Information Technology

3.3.2. The Department is requesting respondents to send any comments or answers, no matter how minor, to the Department. Respondents are encouraged to address the questions listed in the Response Worksheet, but you do not have to reply to all of the questions in a section.

3.3.3. Please note that early responses are appreciated. Respondents do not need to wait until SUBMISSION DATE (see Section 2.4) to submit comments. The Department appreciates receiving any and all comments from respondents.

3.3.4. Reponses should be emailed to RCCORFP@state.co.us. Your answers may be submitted as an attachment or an email. If they cannot be emailed, they may also be sent, in hard copy, to: Colorado Department of Health Care Policy and Financing, Attention: ACC Team, 1570 Grant St., Denver, CO 80203. Following receipt of your response, you should receive a confirmation email within three (3) business days.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Averil Strand
Location: Fort Collins, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Larimer Co. Dept. of Health and Environment
Location: Fort Collins, CO
X Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
   i. Type or specialty: Click here to enter text.
   ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
X☐ Other (please describe): Public Health Dept

Are you currently involved in the ACC program?

X Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
X 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
We have had meetings with the two RCCOs in our area to coordinate services. I also participate in the Region 2 Hot Spotter calls.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
We provide immunization and family planning services for clients on Medicaid. We have the Healthy Communities office in our department.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
X Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Although we tried in the beginning to be included in providing services, the RCCO decided to hire their own staff to perform care coordination services. They refer to us for things like care coordination for children with special health care needs but do not contract for these services.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

The care coordinators are helping to reduce costs and improving the quality of life of individuals by working with very high risk, high cost patients within the community. This often includes those with multiple emergency room visits and mental health and substance abuse concerns.

2) What is not working well in the ACC Program?

Larimer County is in region 1 but because of the FQHC in Loveland being part of Sunrise, we have region 2 involvement as well. The region designation does not make sense for this Front Range community to be linked to the western slope. Initially it was difficult for new staff to know what already existed within a community so that multiple entities might be involved in care coordination. It also seems unfortunate that the health department gets referrals but no income when we do care coordination. As the services broaden into more women and children's issues, I hope that the ACC will keep in mind that the health department is available to provide Reproductive Health Services, Care Coordination for Children with Special Health Care needs, WIC Services, Immunization services, TB management, etc.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

With the Affordable Care Act in place they are better able to hire additional staff to meet the needs of populations that heretofore were locked out of care.

4) What is not working well in the BHO system?

Screening, referral and treatment services are often not initiated early.

5) What is working well with RCCO and BHO collaboration right now?

Medicaid is helping to cover costs so that more people in need can be served. They are treating people with duel diagnoses.

6) What is not working well with RCCO and BHO collaboration right now?

The support services needed within the community (housing, transportation, etc.) are limited which makes it more difficult to stabilize at risk clients.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Helping to find more support options to stabilize living conditions of the at risk populations.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services**. Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	X	☐	We have no detox center and no funding source to create one. We have inadequate in-patient beds.
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	X	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	X	☐	They are hiring – this will help
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

Individuals would need to have services available for screening for behavioral health issues and support for their providers to offer resources at the site where they are getting their physical care.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

It is important to get medical providers to have consistent evidence based tools that they use for early identification and referral for services. Although it would be ideal to have behavioral health services always available in general medical offices so that there is not a referral process this is not realistic in small practices. I believe that medical providers need better accessibility to behavioral health specialists and psychiatrists while a patient is in their offices so that some services don't have to be referred out.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient. Developing relationships with clients and working with them to improve their health by putting supports into place to keep them from needing crisis intervention and prevent exacerbation of disease processes is essential. Care Coordinators need to assure that patients are getting the services needed through a medical home approach.

b. How should RCCOs prioritize who receives care coordination first?

Right now, I think they have focused on high cost clients. This has sorted itself out to mean a lot of low income, high needs people often with drug, alcohol abuse and mental health issues with poor living conditions.

c. How should RCCOs identify clients and families who need care coordination?

By working with Medical Home Providers. By looking at the medical history and cost centers.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

They could report on who is doing the care coordination the RCCO care coordinator or someone else.

12) What services should be coordinated and are there services that should not be a part of care coordination?

I think that the care coordinators need to think broadly about their clients and coordinate with the services available in their individual communities. So for example if they have a pregnant, drug abusing client, it would be good to get that client into a community program to try to improve the outcome for the baby- these programs may be available through health departments or BHO's. If they have a family situation where there are many children, it would be good for them to think of the family planning needs of the parents so that they can limit the size of their family if they are struggling. If there is a communicable disease involved they need to know what are reportable diseases and involve health departments in those early.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

What is their health status. Do they have potential for improvement. What are their living conditions and supports.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

    a. What care coordination is going on today?

Referrals into community and medical services.

    b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

The Health Care Program for Children with Special Needs works in an advocacy position to get the services in place, even if it costs more to meet the client's needs. Often these children will have a lifetime of expenses and clinical services and the families are helped to know how to work with the systems and community organizations to best meet their children's needs to reach their maximum potential in life. Often Health Departments will work with undocumented families who will not initially show up in the RCCO system. For example a woman may not receive Medicaid supported prenatal care, get emergency Medicaid for the delivery but the child is then a citizen. The preventive care needed during the pregnancy is important for the outcome at delivery. The NFP and Prenatal Plus programs are coordinated out of the Health Department. Some private providers feel that they are providing their own care coordination. Healthy Communities helps to work out Medicaid eligibility problems and people who are inadvertently dropped or denied Medicaid services – then they can link them to a medical provider for their care.

    c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

By being sure that their new coordinators get an adequate orientation to the community.

    d. What are the gaps in care coordination across the continuum of care?

Gaps exist when the needed services are not available – for example meeting the needs of the homeless population. Care coordination is focused on high cost users – there probably will never be enough care coordinators to help people navigate unfamiliar systems. When people are moved onto and off of Medicaid and CHP+, care coordination is not on a continuum.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs**. Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	X	☐	X	They should be mandatory reporters for abuse and neglect.
Affordability (assistance with prescriptions or co-pays)	X	☐	X	The Health District of Northern Colorado has a good prescription assistance service in place. The RCCOs could assist when non-generic drugs should be used – this often happens with mental health diagnoses.
Daycare / childcare	X	☐	X	
Economic stability & employment	X	☐	X	
Education	X	☐	X	Health Education and coordinating with existing programs
Environment	X	☐	X	
Food access / nutrition	X	☐	X	
Health literacy	X	☐	X	
Housing	X	☐	X	
Language or translation services	X	☐	X	
Literacy	☐	☐	☐	
Transportation	X	☐	X	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination**. Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	x	☐	For those needing a more advanced knowledge in providing complicated care.
Certified Addiction Councilors	X	☐	For those who are struggling with addition.
Certified Nurse Midwives	☐	X	I think this would be a duplication of available services
Community Health Workers	X	☐	For lesser diagnosis or specific subject areas these individuals can be less expensive and still be effective.
Generalists (BA/BS/MA/MS)	☐	X	
Health Coaches	X	☐	Potentially could help with group education
Licensed Clinical Social Workers	X	☐	To coordinated Social Service needs.
Licensed Marriage and Family Therapist	☐	x	
Licensed Mental Health Counselors	/x	☐	They need to be able to identify and refer.
Licensed Professional Counselor	☐	X	I don't know what kind of counseling is in their background
Masters of Public Health	X	☐	Community Development around Health issues.
Medical Doctors / Doctors of Osteopathic Medicine	☐	X	These individuals are more trained in direct care and not so much in care coordination.
Nurse Practitioners	X	☐	For those needing a more advanced knowledge in complicated care. However, if there emphasis is on providing clinical services it is probably not a good fit.
Patient Navigators	X	☐	A lot of clients have no idea how to navigate systems and these people can help.
Peer Advocates	☐	☐	Unsure
Promotoras	X	☐	For lesser diagnosis or specific subject areas these individuals can be less expensive and still be effective.
Psychiatrists	☐	x	These individuals are more trained in direct care and not so much in care coordination.
Psychologists	x	☐	As long as it is not duplicating existing services

Registered Nurses	X	☐	These people have a good concept of cross cutting health issues.
Social Workers	X	☐	Often these individuals are good at accessing resources.
Wraparound facilitators	☐	☐	Unsure
Other	Please type your response here.		

17) **Care coordination requirements for specific populations**. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	X	We provide post partum home visitation to all women who deliver on Medicaid. Not all county's are able to do this. These families need knowledge and linkages when they come home from the hospital regarding safety issues like safe sleep environments for their babies, breastfeeding, jaundice, etc.
Children	☐	X	
Children who are healthy, but in socially-complex environments	☐	X	
Children involved in the foster care system	☐	X	They should receive services through Human Services. Foster families do need access to health histories so that adequate preventive as well as restorative and mental health services can be provided.
Children with a chronic illness	X	☐	Some children with chronic illnesses can better adapt with direct care coordination. Examples would include children with Asthma or diabetes.
Children with a serious emotional disturbance	X	☐	These children do not always fit with the requirements or focus of providing agencies.
Children with medical complexity	☐	X	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	X	
Transition-age adolescents	☐	X	
Parents and families	☐	X	
Pregnant women	☐	X	
Adults	☐	x	
Adults who are healthy, but in socially-complex situations	☐	x	
Adults with a chronic illness	x	☐	This may require some specific intervention to get them on the right track with follow up for compliance.
Adults with a behavioral health diagnosis or substance use disorder	X	☐	These individuals need monitoring to help them stay on track.
Clients involved in the criminal justice system	☐	X	

Clients with a disability	X	☐	This need would be appropriate with some disabilities.
Clients in a nursing facility	☐	X	
Elderly clients	☐	X	
Frail elderly clients	☐	X	
Clients in palliative care	☐	X	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

They should coordinate with the Health Care program for Children with Special Needs. They should help to assure that these children have access to preventive services not just disease or disability related services. They should help to assure that information is available for children in the foster care system to help with continuity. They may need to be linked into accessing more trauma related services for those in foster care. Kinship care is important to relate to – not just foster care.

19) How should care coordination be evaluated? How should its outcomes be measured?

Health improvement and cost.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

Yes – there are some very complex patients who are not easily motivated and changed who require a lot more time and effort.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

I don't know what is reasonable but I think a client ratio should be adequate to assure that people actually get services.

a. **Care coordinator to client ratios**. If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

That they have the capacity to know and/or learn the community resources and needs.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

In Larimer County it is difficult to have two RCCO's in the same county.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. Larimer County should be included with Front Range communities.

28) Should the BHO region maps change? Why or why not? If so, how?

I don't know.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

Even though some improvements have been made, churn is a problem when people go onto and off of Medicaid and other insurance products.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

We already have that in Larimer and it is confusing.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

There should be agreements in place to refer clients for immunizations to local departments when their provider does not carry vaccine. There should be knowledge of communicable disease reporting requirements and responsibilities. There should be knowledge of and referral to locally based Programs like Nurse Family Partnership, Prenatal Plus, Family Planning, Sexually transmitted disease services, tuberculosis, WIC, Healthy Communities.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

See 35. NFP and Healthy Communities contracts are no longer with CDPHE

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

They have to work with clients, families and advocates if they expect changes in behavior.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

RCCOs should have open accessible meetings quarterly to keep updated on changes and should meet with major stakeholders individually to work out systems.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

Contracting should take place with organizations when appropriate.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

They should provide a website, community meetings and an open opportunity for input.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

Somewhat – they are not focusing on the entire eligible population.

a. If no, what are the gaps?

We do not have adequate detox or mental health in-patient beds or alcohol and drug abuse treatment centers. I don't know how the ACC deals with this but it is a gap.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

ACC's are often focused on cost containment. Health Department programs are focused on accessing needed services for enhancing lives and reaching maximum potential. These can sometimes be at cross purposes.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

They should not be in control of the system by having the care coordinators work out of their facilities. This is especially true when multiple hospital systems are in the same community.

b. What role should pharmacies play in the next iteration of the ACC Program?

With adequate oversight, they can be very beneficial in medication management. If they are to be involved with immunizations, it is important to make sure that they have adequately monitored refrigeration.

c. What role should specialists play in the next iteration of the ACC Program?

Consultation

d. What role should home health play in the next iteration of the ACC Program?

Referral for care.

e. What role should hospice care play in the next iteration of the ACC Program?

Referral for care

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

Unsure

g. What role should counties play in the next iteration of the ACC Program?

They should have a knowledge of the costs and savings provided.

h. What role should local public health agencies play in the next iteration of the ACC Program?

There should be coordination, referral and perhaps contracting with these agencies.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

There are agencies that provide services for high risk youth – referred out of drug court, etc. who do not receive paid services. I think coordination could improve with places like "The Center for Family Outreach" in Larimer County.

45) How can RCCOs help to support clients and families in making and keeping appointments?

Help solve transportation issues, do reminder calls, link to community health workers.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

Potentially.

47) **Community Health Worker reimbursement**. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	This could be on staff with a community organization like the Health Department paid through a RCCO contract
On staff (salary) at RCCO	X
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

Assessing that the providers actually routinely take Medicaid – not just one or two who had previously been their patient.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

The ability to interact effectively with people of different cultures, disabilities and socio-economic backgrounds.

b. What RCCO requirements would ensure cultural competency?

Staff should be interviewed when being hired regarding their cultural competency. Training should be provided.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

They need to listen to what is meaningful and needed by the participants and use their goals in determining ways of accomplishing improved health. They should not use acronyms and should focus at no higher than a 6th grade level in communications. They should have written materials in other languages than English.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

The use of language lines, people from targeted cultures and communities. They should test their written materials for reading level.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

Yes

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Assure that adequate services outside of the ER are available and communicate how to use them. For populations who have only had access through ER's it may take some education with those departments to redirect people when they are not in crises.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices**. Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience**. Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment**. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication**. For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type**. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☐
Care management tool	☐	☐	☐	☐	☐
Care transitions alerts	☐	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☐
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

81) How can Health Information Technology support Behavioral Health Integration?

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Appendix: Definitions and Acronyms

The following words have been defined for the purpose of this RFI.

42 CFR is a federal regulation outlining when information about someone's Substance Use Disorder (SUD) treatment may be disclosed with or without his or her consent.

Accountable Care Collaborative (ACC) Program is Colorado Medicaid's program designed to affordably optimize Client health, functioning, self-sufficiency, and well-being. The primary goals of the ACC Program are to improve Medicaid Client health outcomes and to control costs.

Attribution is the process of connecting Clients to primary care medical providers in the ACC Program.

Behavioral Health Organizations (BHOs) are the five regional entities responsible for arranging mental health and substance use disorder services for Colorado Medicaid Clients. Almost all Medicaid clients are enrolled in a BHO when they receive Medicaid. The BHOs get a set amount of money to manage the care for Medicaid clients. The BHOs reimburse their network of providers for delivering services to those clients.

Behavioral Health Integration is the process of delivering behavioral and physical health care together. When a Client is a partner in integrated care, he or she (along with his or her family or other support structure) has access to broader, more comprehensive care.

Care Coordinator is someone responsible for the coordination of a person's medical and non-medical care. In the ACC, care coordinators may either work for RCCOs or at primary care clinics.

Client is a person who is enrolled in the Colorado Medicaid program.

Clinical Quality Measures are used to assess the performance of individual clinicians, RCCOs, providers, or programs. Measures are often backed by evidence to support their association with improved health outcomes.

Colorado Regional Health Information Organization (CORHIO) is a non-profit organization in Colorado that serves the health care industry with health information technology functionality. It is a Health Information Exchange (HIE) which helps to securely transmit all kinds of health care data between providers, hospitals, pharmacies, and other entities.

Community Behavioral Health Services Rule is the name of the state's regulation which governs community mental health services. It defines the populations which are, and are not, eligible to receive services, the service types which are covered, and the structure through which payments are made. It is found in the Colorado Code of Regulations, 8.212.

Community Centered Boards (CCBs) are Colorado's 20 private, non-profit organizations that serve as single entry points into the long-term service and support system for persons with developmental disabilities. Community Centered Boards may also provide services.

Community Health Workers (CHW) are non-traditional, lay health workers who provide coordination or education, assist people in managing their health, or help people to navigate the health care system in their community.

Community Mental Health Center (CMHC) is an entity that provides behavioral health services for Medicaid clients. In Colorado, In Colorado, CMHCs are generally paid by the Behavioral Health Organizations, essentially on a per-capita basis, rather than reimbursement for each service rendered.

Covered diagnoses list is a list of roughly 350 behavioral health diagnoses. Any client may be assessed by a BHO provider, regardless of diagnosis, but in order to have ongoing services paid by the BHOs, clients must have a covered diagnosis.

Department of Health Care Policy and Financing (the Department) is the state agency that administers the Medicaid and Child Health Plan *Plus* programs as well as a variety of other programs for Colorado's low-income families, the elderly, and people with disabilities. Our mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources. This means that we work to make our clients healthier while getting the most for every dollar that is spent.

Fee-For-Service (FFS) is a way of paying for services where providers are reimbursed a set amount for each service they provide such as an office visit, test, procedure, or other health care service.

Health Insurance Portability and Accountability Act (**HIPAA)** is a federal law designed to provide privacy and security standards to protect patients' medical records and other health information. These standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed.

Health Information Exchange (HIE) is an electronic system capable of sharing secure health care records and information between different providers or other entities in the health care system.

Health Information Technology (HIT) is any computerized system for health care data or records.

Health literacy is a term used to describe how comfortable and capable a person is obtaining, understanding, and using health care information to make decisions about his or her health.

Institutions for Mental Diseases (IMD) exclusion is a federal regulation that prohibits Federal Medicaid payments for clients aged 21-64, receiving care in institutions with more than 16 beds, when more than half of the people being served have a serious mental illness or substance use disorder.

Key Performance Indicators (KPIs) are utilization and quality measures which are tied to payment in the ACC Program. KPIs are used to incentivize RCCOs and providers.

Medical Home is the focal point of care for a client. Medical Homes provide coordinated and comprehensive primary care services. Throughout the RFI, the term "Medical Home" is used in a general sense. It does not refer to a specific model or licensure requirement. However, there are some common qualities that Medical Homes should have. These include: improved Client access to care that is coordinated, integrated, whole-person/family-oriented, culturally competent, and outcomes-focused.

Member is any Medicaid Client who is enrolled in the ACC Program.

Office of Behavioral Health (OBH) is a state office which is part of the Department of Human Services. OBH is tasked with monitoring, evaluation, and oversight of Colorado's public behavioral health system.

Payment Reform is the term used to describe the process of moving away from paying for volume and towards paying for value in the health care system.

Per-Member Per-Month (PMPM) is a per-person payment method that makes a fixed payment per enrollee each month, regardless of actual number or nature of services provided.

Practice Support is the process of supporting a provider in the transition towards becoming a more effective Medical Home.

Primary Care Medical Provider (PCMP) is a primary care provider contracted with the ACC Program. These providers may be FQHCs, RHCs, clinics, or other practices that provide the majority of a Member's comprehensive primary, preventive, and sick care. PCMPs are reimbursed fee-for-service, but they also receive a per-member per-month payment and can receive KPI incentive payments.

Quality Health Network (QHN) is a Colorado-based nonprofit operating in the field of health information technology. QHN operates a health information exchange platform which serves people living in Western Colorado.

Regional Care Collaborative Organizations (RCCOs) are the regionally-based entities responsible for ensuring care coordination, achieving improved health outcomes and improved well-being for their clients, and ensuring cost savings for the ACC Program. RCCOs leverage local infrastructure, relationships, and community resources to ensure clients receive the right care, at the right time, in the right setting. RCCOs are paid by the State on the basis of a per-member per-month payment which covers all of their responsibilities.

Single Entry Points (SEPs) are usually county agencies which provide case management, referrals, and care planning to Clients receiving Long Term Services and Supports.

Statewide Data and Analytics Contractor (SDAC) is the entity with which the Department contracts to provide data aggregation, analysis, and distribution in support of the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 002

Accepted by: KJDW

Notes: Responses inserted into standard RFI worksheet

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Irene Aguilar
Location: Denver County, SD 32

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Click here to enter text.
Location: City, County, State.
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☒ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☐ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Click here to enter text.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

- I think the ACC and BHO areas should be one and the same. They should be required to work together;
- Consideration should be made of making these areas the same as the insurance geographic rating areas.
- I am concerned about having DHHA both in and outside of the RCCO (managed care and RCCO). Seems to add a layer of confusion and complexity.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 003

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Bebe Kleinman
Location: Littleton, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Doctors Care
Location: Littleton, Colorado
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: family practice
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☒ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
We are a pcmp and have a staff member on the RCCO committee

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
90% of our patients are insured by Medicaid

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

Active participation by Medicaid and community

2) What is not working well in the ACC Program?

Not enough access to many physician types or specialty care

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

We need to credential more providers more quickly, especially Spanish speaking.

5) What is working well with RCCO and BHO collaboration right now?

They are talking to each other

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

We need to open up a code for navigation as this would help link the needs of the physical, mental, and social needs of our patients.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☒	☐	Reimbursements don't motivate private providers to take MC patients.
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☒	☐	We need access, even phone access to psychiatrists. The CPACK pilot is wonderful. This needs to be expanded to patients through the age of 30.
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☒	☐	We need more Spanish speaking staff
RCCO or BHO contracts	☐	☐	
Staff capacity	☒	☐	Improve reimbursements and more providers will join the network.
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Others	Please type your response here.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

The BH therapist works directly with the medical providers within the clinical setting.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

Follow up with high utilizers

b. How should RCCOs prioritize who receives care coordination first?

High utilizers is a good place to start but it does not focus enough on meeting the patients psycho social needs which may cause the patient to use health care in a certain way.

c. How should RCCOs identify clients and families who need care coordination?

Unless the clinics are reimbursed to provide wrap around services for patients it is difficult to ask the clinics to identify even more patients that need the services.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

We need to ask the patient what they believe are the biggest challenges they face that seem to be contributing to their high utilization of ER's, imaging, etc.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

Absolutely this is happening. Maybe care coordination needs to be identified in the medical record and then this information would be shared through the HIE so hospital, mental health, pcmp offices will know what else is being provided elsewhere.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

So much is happening outside the RCCO. As a safetynet provider we are looking at food, housing, managing the bills that pile up and overwhelm people. We are looking at family stress, job stress, and literacy challenges. These all impact the health and health access of the patient.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

Insure that messaging to the patients and the providers are transparent and easy to read and follow. It is shocking to see some of the letters sent to patients that are written in a way that is so confusing. Send clear messages and then let the providers know what you are telling the patients.

d. What are the gaps in care coordination across the continuum of care?

Often there is very little link between the 'medical care coordination' mandated by the ACO and the 'social' navigation work that is being done.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☒	
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	
Daycare / childcare	☒	☐	☒	
Economic stability & employment	☒	☐	☒	
Education	☒	☐	☒	
Environment	☒	☐	☒	
Food access / nutrition	☒	☐	☒	
Health literacy	☒	☐	☒	
Housing	☒	☐	☒	
Language or translation services	☒	☐	☒	
Literacy	☒	☐	☒	
Transportation	☒	☐	☒	

Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☒	To be financial efficient, everyone should work at the top of their license but they need to have access to these services, and it is helpful when it can be in the clinical setting
Certified Addiction Councilors	☐	☒	To be financial efficient, everyone should work at the top of their license but they need to have access to these services, and it is helpful when it can be in the clinical setting
Certified Nurse Midwives	☐	☒	To be financial efficient, everyone should work at the top of their license but they need to have access to these services, and it is helpful when it can be in the clinical setting
Community Health Workers	☒	☐	
Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☐	☒	To be financial efficient, everyone should work at the top of their license but they need to have access to these services, and it is helpful when it can be in the clinical setting
Licensed Marriage and Family Therapist	☐	☒	To be financial efficient, everyone should work at the top of their license but they need to have access to these services, and it is helpful when it can be in the clinical setting
Licensed Mental Health Counselors	☐	☒	To be financial efficient, everyone should work at the top of their license but they need to have access to these services, and it is helpful when it can be in the clinical setting
Licensed Professional Counselor	☐	☒	To be financial efficient, everyone should work at the top of their license but they need to have access to these services, and it is helpful when it can be in the clinical setting

Masters of Public Health	☒	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☒	To be financial efficient, everyone should work at the top of their license but they need to have access to these services, and it is helpful when it can be in the clinical setting
Nurse Practitioners	☐	☒	To be financial efficient, everyone should work at the top of their license but they need to have access to these services, and it is helpful when it can be in the clinical setting
Patient Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☒	☐	
Psychiatrists	☐	☒	To be financial efficient, everyone should work at the top of their license but they need to have access to these services, and it is helpful when it can be in the clinical setting
Psychologists	☐	☐	To be financial efficient, everyone should work at the top of their license but they need to have access to these services, and it is helpful when it can be in the clinical setting
Registered Nurses	☐	☐	To be financial efficient, everyone should work at the top of their license but they need to have access to these services, and it is helpful when it can be in the clinical setting
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	The care coordinators need to be skilled in transferring to other services quickly and efficiently. I would say this for every specific group. They need to be generalists.
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

Foster children need flexibility so they can be placed in the most appropriate home, not limited by the boundaries of the RCCO or the county. It is very frustrating when a child that comes out of Denver is placed in another county and then the Foster Parent can't take the child to their local provider. It is not good for the child nor the foster parents.

19) How should care coordination be evaluated? How should its outcomes be measured?

Let's ask the patient if they are better off today then they were before they met with care coordinators.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

This PMPM does not cover the cost of navigation support which we define as non medical in nature.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

Each person's needs is so individualized that it would be difficult to place a price tag on different populations. A 20 year old male may have as many needs as a 55 year cancer patient, or an 8 year old with ADHD. It is not the disease or condition that defines the individual.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

I just don't have an answer for this.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

All these are good

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Relationships and strong connections are valuable. Most RCCOs can be active participants in their local health alliances.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This may help us avoid the current challenge many of us face that Denver Health automatically enrolls everyone from Denver. This is not best for the patients.

27) Should the RCCO region maps change? Why or why not? If so, how?

Maps should all align as much as possible. Physical, behavioral, dental.

28) Should the BHO region maps change? Why or why not? If so, how?

Maps should all align as much as possible Physical, behavioral, dental.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

Give all practices an incentive to help patients enroll.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

The lack of cooperation during the first year of enrollment was obvious and made the work to gain coverage a challenge. We are all hoping that these two entities do a better job working together during this next open enrollment period.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

Yes we must hear from the patients in some meaningful way.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

Yes we must hear from the patients in some meaningful way.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

Work closely with the health alliances in each community and the safetynet.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

Specialty care is a very real challenge. Medicaid must figure out how to rebrand. Reduce the paperwork. If this survey is any example, community feedback will be very limited. Instead of focusing your questions on what you need to know, you ask the same questions over and over and alienate the same folks you need advice from. This survey illustrates how out of touch you are from the real world.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

This could be really wonderful.

47) **Community Health Worker reimbursement**. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☒
On staff (salary) at Primary Care Medical Provider Clinic	☒
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☒

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

This is a major crisis. The network cannot support all the newly insured. Help the safetynet expand. These are the low hanging fruit. Asking private dentists to take on 5 more MC patients will not meet the needs.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

We need to look upstream to figure out what is causing this increase in ER utilization. No one is doing this.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☒	☐	☐
Network provider education	☐	☒	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☒
Provide web-based resources and directories	☒	☐	☐	☒
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☒	☐	☐	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☒	☐	☐	☐
Provide registries	☒	☐	☐	☐
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☒	☐	☐	☐
Supply behavioral health surveys	☒	☐	☐	☐
Supply other self-screening tools	☒	☐	☐	☐
Administer behavioral health surveys	☐	☒	☐	☐
Administer other self-screening tools	☐	☒	☐	☐
Prepare client action plans	☐	☒	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☒	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☒	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☒	☐	☐	☐
Provide standing pharmacy order templates	☒	☐	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☐
Provide directory of other resources	☒	☐	☐	☐
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others	All these items exist in the free market but because of cost we don't always use or access them.			

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

All the items would improve care but if you require them then you will alienate even more private practices from taking MC.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

A place to start may be to share best practices.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

Require is a high expectation and you will alienate more docs.

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

Health coaches or navigators would support the patients needs.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☒
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

National standards.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☐
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☐	☒
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☐
Care management tool	☐	☐	☐	☐	☐
Care transitions alerts	☐	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☐
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

81) How can Health Information Technology support Behavioral Health Integration?

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

This survey illustrates why it is so difficult for the ACO and the RCCO's to build relationships with providers. You built a bureaucracy in this 36 page document. This should have been divided into manageable surveys for different types of people you want feedback from. Patients, community workers, practices, potential RCCO partners, business community, general public. Let people define where they best fit using a decision support tool. Each survey gets to be no longer than 25 questions. I would not recommend anyone take the time to fill this out because it is so unwieldy and exhaustive and it doesn't feel like anyone will analyze my answers. I skipped a bunch of questions as I don't have enough solid information or experience to attempt an answer.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 004

Accepted by: KJDW

Notes: Responses inserted into standard RFI worksheet

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: William S. Hildenbrand
Location: City, County, State.

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Savio House Inc.
Location: Denver, CO
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☐ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Click here to enter text.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

2) What is not working well in the ACC Program?

There haven't been opportunities for providers to integrate with the ACC efforts.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

Colorado Access is determined to use evidence based programs and other services where measured outcomes show positive and sustainable outcomes. They reach out to community providers for the services. They don't confuse roles between being a BHO and service providers. Others not so much.

4) What is not working well in the BHO system?

The problem comes about when the BHO or their affiliates become providers of the Medicaid services. Roles become blurred and conflict of interest issues appear. It should be if you are a BHO or MCO, you aren't a provider.

Secondly, As soon as a child/family show improvement, medical necessity in the eyes of the BHO goes away and payments stop. They don't seem to understand, if you want the successful outcome of an evidence based program, you have to give it in full dose. I understand their goal is to manage care and prevent endless services, but EBPs give everything that is needed and not one more moment of service.

5) What is working well with RCCO and BHO collaboration right now?

I can't comment on this question or the one below as opportunities to interact haven't been available.

6) What is not working well with RCCO and BHO collaboration right now?

I can't comment on this question or the one below as opportunities to interact haven't been available.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

All parties including providers at the table. The goal as outline in the recent ACC webinar sounds great. The proof is in the outcome, ie, how is it implemented?

[1] Many terms and definitions can be found in the Appendix at the end of this document.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 005

Accepted by: KJDW

Notes: Adjusted formatting for question 47 (CHW reimbursement)

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Dorothy Perry, PhD
Location: Pueblo, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: BHO - Colorado Health Partnerships & RCCO 4 – Integrated Community Health Partnership
Location: Western/Southern CO
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☒ Potential bidder for RCCO contract
☒ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☒ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:

The Western Southern region of the BHO Colorado Health Partnerships (CHP) is in the geographic region of RCCO 4, of which Spanish Peaks Behavioral Health Centers is a partner in both organizations.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Spanish Peaks BHC covers three counties in both the BHO and the RCCO regions referenced above.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

   - Whole person healthcare encompassing both the body and the mind for individuals seeking healthcare services.

   - RCCO administrative and clinical services are being provided by managed care organizations and providers who live and work in the same communities as those they care for under this contract. Services and resources are customized based on patient need, community assets and deficits, as well as local community culture.

2) What is not working well in the ACC Program?

   - Payment reforms are moving too cautiously to have substantial impact on cost and quality of care. We are still largely tied to a fee for service system that is volume driven and not focused on quality and cost outcomes.

   - Often times healthcare professionals change the definition of healthcare integration rather than changing the way they practice. Small convenient changes will not achieve true integration within our healthcare systems. Instead we need to invest in those we look to for leadership in the process, our primary care providers. We cannot assume because they are a physician and have a medical degree that they have a true understanding or investment in integrated care, nor that they have the necessary leadership skills to lead an integrated team of multi-specialty providers.

   - Allowing medical providers to have lower expectations on work performance and documentation than behavioral health providers is counterproductive. Often time's medical providers have no requirements or expectations of developing and carrying out treatment plans, minimal documentation requirements, and avoid various other mandates that the BHO Medicaid contract requires (e.g., CCAR, mobile crisis, appointment timeliness, etc.). Having integrated standardized expectations will improve patient treatment and will help to build a more cohesive treatment team for patient care.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

   The BHOs have been able to control costs since capitation's inception in 1995 while providing access to more members while managing ever increasing administrative and clinical mandates. BHOs have successfully managed provider risk which must be a key component of any payment reform initiative.

4) What is not working well in the BHO system?

   - In a fee-for-service system payors are worried that providers will provide more service than is medically necessary, in an effort to earn more revenue. In a capitated system payors are concerned that providers will provide fewer services than is medically necessary as a means to pocket excess capitated revenue. In Colorado, due to the latter concern, HCPF and CMS are focused on counting

widgets (i.e., billing codes, units of service, RVUs, and dollars) to hold providers accountable for the revenue received in the capitated system. What's not being address is if those we are treating are improving, maintaining their illness without an escalation in symptoms, or if in spite of a patient's illness has found ways to improve their quality of life.

Most will not be able to terminate their illness, although some will. Many in spite of their illness can learn coping skills or to manage their illness in a manner that allows them to live in their chosen community, care for themselves, and have relationships with family and friends. This is what providers need to be paid for – patient outcomes. What we are in need of an outcome based reimbursement model that measures:

- Physical Health:
  - Symptoms - pain, fatigue, dyspnea, gastro-intestinal, physical stress experiences
  - Functions – physical activity, sedentary behavior, strength, sleep, sexual
- Behavioral Health:
  - Affect – negative and positive
  - Behavior – substance use, self-harm, isolation, anxiety, depression, violence
- Social Health:
  - Relationships – social isolation, quality of social support, peer relationships
  - Family – level of support, involvement, access
  - Function – ability to participate in relationships and social functions
  - Satisfaction – relationships, social activities, quality of life
- Daily Living
  - Housing, food, clothing
  - Employment and education

http://www.nihpromis.org

- When patient outcomes improve, healthcare cost will go down or at least be maintained. There are no billing codes for many of the above items and the interventions they may require. My guess is that CMS will still want to count widgets, so in our global capitation waiver we need to have an additional avenue to measure success rather than billable units, RVUs and cost – we will need a quantitative way to measure our investment and outcomes in the above whole person care factors.

5) What is working well with RCCO and BHO collaboration right now?

- The joint RCCO and BHO meetings have been beneficial. In our BHO we have three different relationships with the RCCOs in our region, RCCOs 1, 4 and 7. What is working is the flexibility to develop local solutions. This feature must be an essential feature of the next RCCO bid.

6) What is not working well with RCCO and BHO collaboration right now?

- There is no SDAC data collaboration with the BHOs. This obstructs opportunities for improved relationships with medical providers and the ability to work collaboratively on patient care and monitor outcomes.

- There is some animosity by some behavioral health providers regarding being held to more rigorous standards under the BHO contract than medical providers, and assumptions that medical providers will never be held to the same rigorous standards as providers in behavioral health.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The RCCO RPF should encourage integration. Bidders should be rewarded with higher scores for closer integration of programs, data and finances.

- An essential aspect of the transition to integration requires tying together levels of integration, governance, and payment reforms, including incentives and performance. Without the combination of all components, we will end up working against ourselves and force movement on one or more dimension without alignment with the others.

- For decades, the body and the mind have been treated separately by various healthcare professions. The treatment of the brain is a major component of primary care. Its blood flow, oxygen level, injuries and physical health affects the five senses, hormones, heart rate, respiration and more. Yet the mind is about the mental faculties and what the mind does in terms of awareness of the world and one's experiences to think, feel, reason, enable judgment, make choices, to have perceptions, memory, and imagination. If we strive to provide integrated healthcare in a manner that 'completes' and 'makes one whole,' we have an obligation to consider that primary care, family practice, and internal medicine must work in a partnership with those who have knowledge and understanding of the mind, and not merely consider them another specialty provider.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

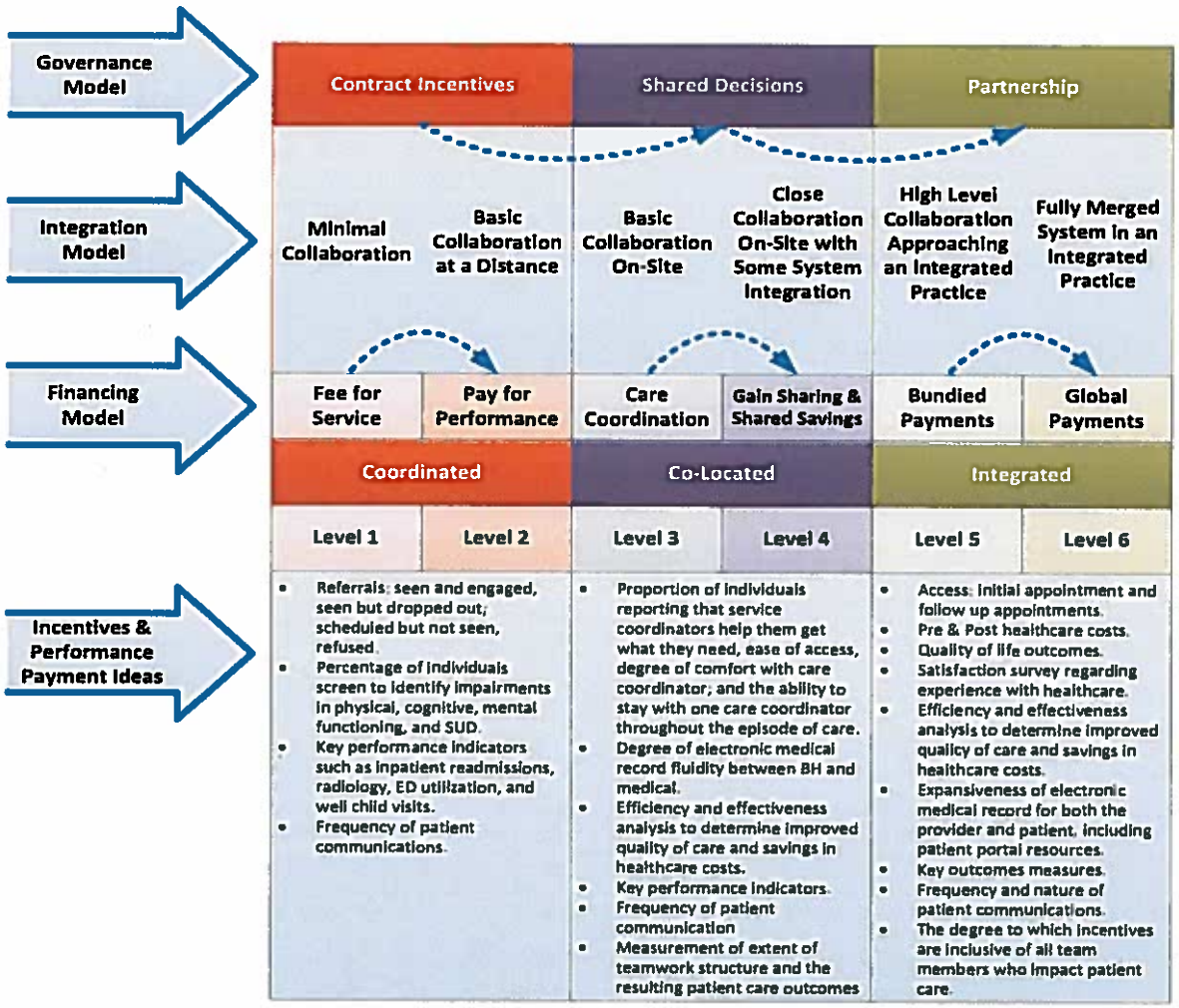
8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	Barrier? No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☒	
Community Behavioral Health Services Rule	☐	☒	
Covered diagnoses list	☒	☐	An expansion on the covered diagnosis list may help with integration, but it also must be managed carefully as opening this up could cause substantial unforeseen costs.
Different behavioral / physical health reimbursement	☐	☒	
Institutions for Mental Diseases exclusion	☒	☐	Although this is an issue, the 1915(b)(3) waiver offers some flexibility through the Medicaid Managed Care program.
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	Very problematic. It would be much better if OBH and HCPF were integrated prior to requiring providers to integrate.
PCMP financing structure	☒	☐	Restrictions on BH physicians receiving payment as the medical PCMC have promotes more of the animosity referred to earlier and obstructs integration.
Per-member per-month amount	☐	☒	
Physical space constraints	☐	☒	
Privacy Laws (HIPAA, 42 CFR)	☒	☐	42 CFR is problematic in providing care coordination services; HIPAA is not an issue.
Professional / cultural divisions	☒	☐	This is a significant challenge, not only with providers, but with executive staff of medical organizations and behavioral health organizations. Because primary care has been heralded as the RCCO lead, they often completely disregard input, ideas, and experience sharing from the BHOs.

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

RCCO or BHO contracts	☐	☒	
Staff capacity	☒	☐	Staff capacity is an issue for all of health care organizations in Colorado.
State/Federal rules or reporting requirements	☒	☐	The rules and reporting requirements need to be aligned, not doing so negatively effects patient care and relations between medical and behavioral health providers.
Technical resources / data sharing	☒	☐	We have found that many medical providers are at a more entry level than BH in the technology arena. For example our local FQHC pharmacy does not accept electronic Rx from our BH medical staff.
Training	☐	☒	
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?



10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Care coordination is a function that supports information-sharing across providers, patients, types and levels of service, sites and time frames. The goal of coordination is to

ensure that patients' needs and preferences are achieved and that care is efficient and of high quality. Care coordination is most needed by persons who have multiple needs that cannot be met by a single provider or by a single clinical organization, and which are ongoing, with their mix and intensity subject to change over time.

b. How should RCCOs prioritize who receives care coordination first?

In a perfect world there would be no prioritization of who gets care coordination, however, resources dictate that there must be some sort of ordering. We have a department of 14 care coordinators in our BH center. Our focus is primarily on two populations, with some exceptions. The first population includes those with serious illnesses in early stages that could exacerbate into more symptomatic and costly conditions if early intervention is not provided. The second population includes those with advanced illnesses that are currently costly, but with intervention we can assist the client in improving the quality of their life and reducing or maintaining costs (these do not include those who are in late stage end of life care).

c. How should RCCOs identify clients and families who need care coordination?

- Collaboration among healthcare providers (i.e., referrals, case staffing's).
- Data reports (i.e., cost, illness, comorbid factors, and outcome measures).

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

Delegated providers should be tracked through periodic onsite audits and data reports.

12) What services should be coordinated and are there services that should not be a part of care coordination?

All services should be coordinated for those needing this type of intervention.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

- Identified concerns.
- The patient's goals.
- Medical, behavioral, and social assessment.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

RCCO care coordinators, physician care coordinators, physicians who contract with others, including the RCCOs for care coordination services, and care coordination for clients who accept this service

offered to them by a RCCO care coordinator, yet the treating physician is not engaged with this process or type of service.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

By centralizing care coordination with the RCCO

d. What are the gaps in care coordination across the continuum of care?

Volume of patients and healthcare provider resources

15) **RCCOs' roles in addressing clients' and their families' non-medical needs**. Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	Should the RCCO have a role? No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☒	☒	
Affordability (assistance with prescriptions or co-pays)	☒	☐	☐	
Daycare / childcare	☐	☒	☒	
Economic stability & employment	☐	☒	☒	
Education	☐	☒	☒	
Environment	☐	☒	☒	
Food access / nutrition	☐	☒	☒	
Health literacy	☒	☐	☐	
Housing	☐	☒	☒	

Language or translation services	☒	☐	☐	
Literacy	☐	☒	☒	
Transportation	☐	☒	☒	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	Part of the CC team, as needed.
Certified Addiction Councilors	☒	☐	Part of the CC team, as needed.
Certified Nurse Midwives	☐	☒	
Community Health Workers	☒	☐	Primary responsibly.
Generalists (BA/BS/MA/MS)	☒	☐	Primary responsibly.
Health Coaches	☒	☐	Primary responsibly.
Licensed Clinical Social Workers	☒	☐	Part of the CC team, as needed.
Licensed Marriage and Family Therapist	☒	☐	Part of the CC team, as needed.
Licensed Mental Health Counselors	☒	☐	Part of the CC team, as needed.
Licensed Professional Counselor	☒	☐	Part of the CC team, as needed.
Masters of Public Health	☐	☒	
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	Part of the CC team, as needed.
Nurse Practitioners	☒	☐	Part of the CC team, as needed.
Patient Navigators	☒	☐	Primary responsibly.

Peer Advocates	☒	☐	Part of the CC team, as needed.
Promotoras	☐	☒	
Psychiatrists	☒	☐	Part of the CC team, as needed.
Psychologists	☒	☐	Part of the CC team, as needed.
Registered Nurses	☒	☐	Primary responsibly.
Social Workers	☒	☐	Part of the CC team, as needed.
Wraparound facilitators	☒	☐	Part of the CC team, as needed.
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☒	
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☐	☒	
Children involved in the foster care system	☐	☒	
Children with a chronic illness	☐	☒	
Children with a serious emotional disturbance	☒	☐	BH involvement/interventions.
Children with medical complexity	☐	☒	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	BH involvement/interventions.
Transition-age adolescents	☐	☒	
Parents and families	☐	☒	
Pregnant women	☐	☒	
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☐	☒	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	BH involvement/interventions.
Clients involved in the criminal justice system	☐	☒	
Clients with a disability	☐	☒	
Clients in a nursing facility	☐	☒	
Elderly clients	☐	☒	
Frail elderly clients	☐	☒	

Clients in palliative care	☐	☒	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

The RCCO should only be involved if there are medical issues.

19) How should care coordination be evaluated? How should its outcomes be measured?

- By a demonstrated reduction of duplicated care and the resulting reduction in medical expenses.
- By a demonstrated improvement in the management of the illness.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

This would require an actuarial analysis.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

Yes, but it would require an actuarial analysis.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

Yes, it should vary by population but needs to be set by an actuarial analysis.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☒
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐

4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

- Cost of care – reduction in wasted care because of un-coordinated care.
- Management of illness – a measurement of alternative illness management solutions (e.g., reduction of Rx usage and increase in activity therapy; reduction of diabetic complication issues and improvement in weight management).

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

I would agree with the list provided above with the exception of provider contracts. Provider contracting creates a competitive edge that saves money for the state and should be left to the RCCO to manage.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

There is a risk in being too authoritarian in the RFP by requiring RCCOs to have specific community relationships. It would be better to have RCCOs bidders describe the relationships they have and how they will enhance those relationships.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is a large population driven approach and would be unsuccessful in rural and frontier areas of the state. There is not enough population in many areas of RCCO 4 to make this work.

27) Should the RCCO region maps change? Why or why not? If so, how?

The state should go to fewer RCCOs and should consider combining RCCO regions 4 and 7. Most care in this part of the state is accessed through two major hubs, Pueblo and Colorado Springs. Having these regions in one RCCO will make care coordination much more effective.

28) Should the BHO region maps change? Why or why not? If so, how?

If the BHO maps were changed a new BHO RFP would have to be issued. I don't think the BHO maps can be change unless the state is ready to combine both the BHO and RCCO programs. To change the BHO maps without combing the programs would be very disruptive to the BHO patients and providers.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

Six months

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

Moving to risk contracts would make the ACC more effective and produce saving more quickly. Allowing RCCOs to manage a PMPM for care could show significant saving.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

- The addition of 9900 codes that allow integrated sights to provide services that are needed would be a major improvement.
- We need to have an additional avenue to measure success rather than covered codes, units, RVUs and cost – we need a quantitative way to measure our investment and outcomes in whole person care factors (i.e., symptoms, functioning, affect, behaviors, social health, and daily living).

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

This is a large population driven approach and would be unsuccessful in rural and frontier areas of the state. There is not enough population in RCCO 4 to make this work.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

Patient choice is of course the first option. Second it past history of the patient – who did they last see (if the patient has no objection to returning to this provider. If they do not have a preference, then an unbiased assignment system needs to be incorporated.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

DOI - only if there is a need for a license because of a risk contract.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

There is a tendency by the state to over burden programs with stakeholder processes and engagement that rarely produces any meaningful outcomes, but may allow the state feel like they have done their due diligence. Most outreach or focus group meetings are poorly attended with input coming from a small population of the same stakeholders who often provide input directly. Suggest that the RPF allow bidders to propose a meaningful stakeholder input process that works for their area.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

Same as above

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

This can be accomplished through the RFP awarding points for community involvement and/or providing incentives.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

See question 39 above

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

No

a. If no, what are the gaps?

Access to specialty care in rural/frontier parts of Colorado is a problematic, as well as assisted living and long term care for those with co-occurring medical and behavioral health conditions.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

The gaps in our area do not seem to be population based.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

The fact is that money needs to be directed away from over utilization expensive hospital care as any real cost savings in healthcare lies that their door ($10 for a single aspirin; $15 for a bandaid?). That is not to say they do not provide a valuable service, but more emphasis on funding models for hospitals that are not fee-for-service must be implemented. As new models of funding are implemented, it would be beneficial to collaborate with hospitals for other types of needed care and services that would help to alleviate the drop in fee-for-service inpatient care for hospitals, as well as provide an avenue for meaning collaboration with hospitals. Areas of possible collaboration could be on alternatives to ER utilization, transitional services from higher levels of care, and specialized services for those with co-occurring medical and behavioral health conditions.

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

Specialty care needs to be more accessible in rural/frontier counties. The ACC program should provide incentives to specialists to provide care in these areas.

d. What role should home health play in the next iteration of the ACC Program?

Home health should be a central part of care planning.

e. What role should hospice care play in the next iteration of the ACC Program?

Hospice care should be readily available to all patients in the ACC program.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

We should use caution in over reaching and involving too many players in the ACC process thus making it burdensome to carry out the main mission of the program to deliver better, more coordinated, cost efficient care to Medicaid members.

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

Please do not loose site of the primary objectives of an ACC. This should be an option proposed by the respondents to the RFP based on patient and community needs and resources. HCPF should be careful not to be too prescriptive in how the RFP requirements are developed. Leaving room for communities to offer meaningful community based solutions should be a key theme of the RPF.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement should be at the discretion of the RCCO and should not be prescribed by HCPF in the RFP.

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

The RCCOs should have a role in coordinating oral health. Oral health need to be a part of overall health care and needs also be integrated.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

It is exemplary customer service that understands local customs, values, goals, and traditions.

b. What RCCO requirements would ensure cultural competency?

The predicament of this question is that any type of requirements cannot attain or improve cultural competency. Asking bidders to describe the uniqueness of their community culture and how they plan to address those needs will give HCPF insight into the bidder's ability to ensure culturally competent services. These values must be imbedded in the organization's culture, and not due to some type of mandate.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all clients/families including those with low health literacy?

Within the limitations of the healthcare workforce shortage, an organization must be as broad based as possible, and what they do not have in-house, they need cultivate within the community.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Please see b. above

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

This should be at the discretion of the RCCO to address regional issues and should not be prescribed by HCPF.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

The RCCO bid should reward the RCCOs for diverting patients from emergency rooms for routine care by developing and implementing more clinical effective and cost efficient services that keep patients from accessing expensive emergency room care.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if **the state, rather than the RCCOs, should offer a platform of support:**

The state should avoid designing a 'package program' for the entire state. While many of these tools, programs, and services are useful, it should be up to the bidders to make a case to HCPF on how these fit the specific community needs and what benefit they believe can result from their use. The state could list these as items of interest from the state, and ask they bidder why/why not these would be beneficial in their community.

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☒	☐	☐
Network provider education	☐	☒	☐	☐
Assistance with practice redesign	☐	☒	☐	☐
Assistance with efficiency-enhancing activities	☐	☒	☐	☐
Provide web-based resources and directories	☐	☒	☐	☐
Provide practice-specific data reports	☐	☒	☐	☐
Provide clinical care guidelines and best practices.	☐	☒	☐	☐
Provide clinical screening tools	☐	☒	☐	☐
Provide health and functioning questionnaires	☐	☒	☐	☐
Provide chronic care templates	☐	☒	☐	☐
Provide registries	☐	☒	☐	☐
Offer client reminders	☐	☒	☐	☐
Offer client self-management tools	☐	☒	☐	☐
Offer educational materials about specific conditions	☐	☒	☐	☐
Supply behavioral health surveys	☐	☒	☐	☐
Supply other self-screening tools	☐	☒	☐	☐
Administer behavioral health surveys	☐	☒	☐	☐
Administer other self-screening tools	☐	☒	☐	☐
Prepare client action plans	☐	☒	☐	☐
Provide training on providing culturally-competent care	☐	☒	☐	☐
Provide training to supporting staff	☐	☒	☐	☐
Provide training on motivational interviewing	☐	☒	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☒	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☒	☐	☐
Provide referral and transitions of care checklists	☐	☒	☐	☐
Provide visit agendas or templates	☐	☒	☐	☐
Provide standing pharmacy order templates	☐	☒	☐	☐
Provide comprehensive directory of community resources	☐	☒	☐	☐

Provide directory of other resources	☐	☒	☐	☐
Provide materials regarding Nurse Advice Line	☐	☒	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☒	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

Again, ask the bidders to propose methods that would address this question.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

Rate enhancements for participation

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

No, again ask the bidder how they plan to manage the health of their population.

58) Please share any other advice or suggestions about provider support in the ACC.

This section is very heavy on requirements and mandates. If these requirements are implemented as RFP requirements it leaves little or no room for creativity, innovation, or meaningful community based opportunities. In a mandated contract, the winning bidder need only to focus on meeting the requirements to be successful rather than focus on solutions that meet the overall goal of population health and community needs. It would be better if the State allows bidder to offer solutions to improve population health and then monitor progress. Publication of outcomes statewide can then allow lower performing providers to learn from others.

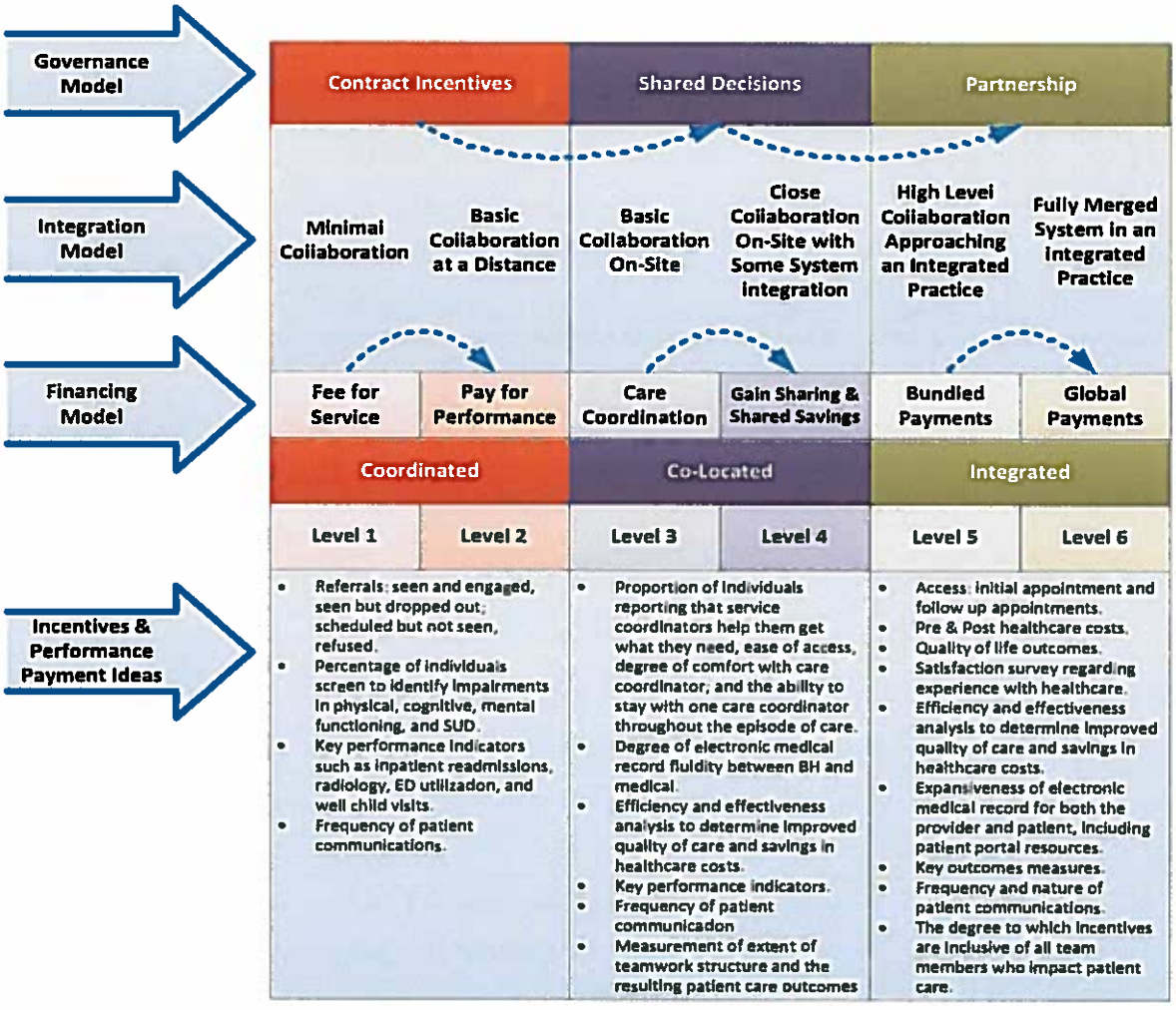
Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

It would be beneficial if the RCCOs moved to risk contracts that provide a PMPM that can be managed against goals for improved population health at a lower or maintained cost.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

As shown below, implementing a payment model that can be gradually transition into from fee-for-service to at least a Level four or five, will promote cost savings and investment in the integrated healthcare model. Depending on population size, some independent private practitioners in rural and frontier areas may have more difficulty in transitioning to a capitation model due to patient volume, as the higher the volume, the more moderated the risk.



61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Not without a transition period. The biggest barrier is the fee for service system of reimbursement. The medical system in place currently is set up to generate volume not value. It will take time, education, and strategic planning for some practices to transition to an at risk model.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

Our BHO organization is licensed by the DOI and we are ready and able to acquire any needed license and the required reserves. A license would not preclude us from bidding. Currently our RCCO is not licensed, but could obtain a license should it be required through additional partnerships or supporting our current managed care partner in becoming an HMO.

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

RCCOs should be completely responsible for reimbursing providers they are required to manage.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

The State should allow broad measures of success for all RCCOs and should allow RCCOs to suggest additional measure that address local needs, at-risk populations in their area, and other innovative customer service projects.

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	This could be the one standardized instrument used across all RCCOs.
SF-12 Health Survey	☐	☒	Allow the bidder to identify outcome measure tools.
Other types of client interviews / surveys	☐	☒	Allow the bidder to identify outcome measure tools.

Patient Activation Measure	☐	☒	Allow the bidder to identify outcome measure tools.
Focus groups	☐	☒	Allow the bidder to identify outcome measure tools.
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

This needs to be the responsibility of the RCCOs, with a requirement to provide outcome data to the State, with periodic audits to assure responsible collecting and reporting of data.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

Open and transparent though a website

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7 at most	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☒
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

A combination of the two would be beneficial as KPIs can address standardized population health, but allow for local indictors to address local community projects/target groups.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Based on improvements

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

The Department need not be constrained by the claims dilemma as RCCOs can develop the systems to monitor progress. These systems can be audited for accuracy to assure the State of their validity. To wait until the State can develop a system could waste valuable time.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential Offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

Examples:

- access standards
- access to providers within acceptable driving distances
- capacity costs to have resources available, but may not be used consistently

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

The BHOs are evaluated on 34 measures but reimbursement is not tied to any of them; our RCCO cap is not paid based on outcomes at this time, but receives performance bonus money.

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☒
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☐	☒
Smartphone app	☐	☒
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☒
Digital care management tool	☐	☒
Care transitions alerts	☐	☒
Electronic Health Records (EHRs)	☐	☒
Health risk assessment software	☐	☒
Practice assessment tools	☐	☒
Practice management tools (scheduling, billing)	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☒
Patient education/wellness tools	☐	☒
Provider/case manager directory	☐	☒
Shared decision-making tools	☐	☒
Telemedicine software	☐	☒
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the 5DAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☒	☐
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☒	☐	☐	☐
Health risk assessment software	☐	☐	☒	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☒	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☒	☐	☐
Patient education wellness tools	☐	☐	☒	☐	☐
Provider/case manager directory	☐	☐	☐	☒	☐
Shared decision-making tools	☐	☐	☒	☐	☐
Telemedicine	☐	☐	☐	☐	☒
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Staff feeling comfortable or being willing to utilize the technology and accept the rules for reimbursement are the primary barriers. Cost is also a barrier in smaller practices in rural and frontier areas.

81) How can Health Information Technology support Behavioral Health Integration?

Information technology will benefit all of healthcare with behavioral health being equally impacted. The ability to reach out to rural/frontier areas will be of special interest to the rural BHOs and RCCOs. Our BHO has invested heavily in tele-medicine for this reason. One challenge we are facing is the integration of medical information. Currently an electronic medical record (EMR) does not exist that can handle both primary care and behavioral health to the full extent of HCPF contact requirements and all the components of integrated care. This is a substantial barrier to Level 6 integration. We are meeting this challenge through creative bridging of two EMRs, but this is not an ideal solution. The expense of having to buy two systems may deter many providers from embracing the true impact that integration can achieve.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

If the RPF required the contracting entities transmit analytics to the state rather than have the state develop a state wide system for data and analytics it could be more cost efficient, effective, and timely. The RFP could require that RCCOs track cost of care; health outcomes and other health come measure and transmit these data in a common platform to the state.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

An effective care management tool must monitor access to care on a real time basis. Care managers need to know when appointments are made, prescriptions are filled, and emergency rooms are accessed. Currently most care management is addressed after the fact and can only prevent future problems rather than intervene in current events.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

This task should be the responsibility of the RCCO. The tool could look at the overall use of care by a population and identify duplicate and inappropriate care so that these trends can be addressed with the providers in the network. This arrangement works best under a risk model where providers are incentivized to be efficient. If the state wants this standardized due to wanting to measure apples to apples statewide, consider engaging the CBHC to assemble a medical and behavioral health committee to develop this tool prior to the next bid.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

The Connect for Health Colorado provider resource guide is a good model for such a directory. Members and care managers should be able to search for provider's base on the needs of the patient.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

The solution is clearly an effective CORHIO and QHN. Anything short of this would not be as effective.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

A combined primary care – behavioral health EMR, the effective implementation of CORHIO/QHN with access for primary care provides, and work with statewide pharmacy's to enable electronic prescribing.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

The RCCOs and BHOs in rural/frontier areas should be the primary source of HIT infrastructure. Most provider groups with the exception of hospitals and FQHCs cannot afford nor can they support the HIT systems needed.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

See question 86 above.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

This was document long and intense. I am concerned about the quantity and quality of feedback you will get due to the length of this RFI.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 006

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Susan J. Hebert
Location: Denver, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Excelsior Youth Center
Location: Aurora, CO
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Behavioral, Mental Health and Educational Services for Female Adolescent Youth
  ii. Area of practice: CEO
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☐ Yes
☒ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Click here to enter text.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

N/A

2) What is not working well in the ACC Program?

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Partnering financially with "best practice" providers of behavioral health and mental health continuum of services, especially Community-based, family-based and community Wrap-Around services who consistently manage to excellent outcomes.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services**. Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	
Community Behavioral Health Services Rule	☒	☐	
Covered diagnoses list	☒	☐	
Different behavioral / physical health reimbursement	☒	☐	
Institutions for Mental Diseases exclusion	☒	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	
PCMP financing structure	☒	☐	
Per-member per-month amount	☒	☐	
Physical space constraints	☒	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☒	☐	
RCCO or BHO contracts	☒	☐	
Staff capacity	☒	☐	
State/Federal rules or reporting requirements	☒	☐	
Technical resources / data sharing	☒	☐	
Training	☒	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

Assurance that evidence-based behavioral health practices are being applied consistently and producing positive behavioral health outcomes.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

Rapid needs assessment and referral to a seamless integrated system of care that can ensure best possible results on clearly identified and mutually-desired goals.

b. How should RCCOs prioritize who receives care coordination first?

Behavioral Health providers are generally agreed on the differing levels of care required for specific behavioral health Hx and symptoms. Collaborating with them is key to determine "triage" decisions for care.

c. How should RCCOs identify clients and families who need care coordination?

Include a brief behavioral health assessment for any patients thought to potentially benefit from this (probably more patients than not since physical symptoms and dx processes are often related to behavioral health dynamics, directly or indirectly).

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

Short-term residential care for quick crisis stabilization, respite for families, family or foster family interventions to stabilize and strengthen family unit and avoid need for higher, more expensive levels of behavioral or mental health care : therapeutic, educational, training, coaching, etc., wrap-around community services, case management,

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

Assessments already exist in Behavioral/Mental\ Health "centers of excellence."

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

Please see above!

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☒	☐	☐	
Daycare / childcare	☒	☐	☐	
Economic stability & employment	☒	☐	☐	
Education	☒	☐	☐	
Environment	☒	☐	☐	
Food access / nutrition	☒	☐	☐	
Health literacy	☒	☐	☐	
Housing	☒	☐	☐	

Language or translation services	☒	☐	☐	
Literacy	☐	☐	☐	
Transportation	☒	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	
Certified Addiction Councilors	☒	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☒	☐	
Licensed Mental Health Counselors	☒	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☒	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☒	☐	
Patient Navigators	☒	☐	

Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☒	☐	
Psychologists	☒	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Please type your response here.		

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 007

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Bobbi Lock
Location: Cortez, Montezuma, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Montezuma County Public Health Department
Location: Cortez, Montezuma, CO
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Public Health Dept

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☒ 2-3 years
☐ 3-4 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Immunizations: pulling eligibility, billing/claims

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Immunizations: eligibility, billing and claims

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

2) What is not working well in the ACC Program?

3) What is working best in the Behavioral Health Organization (BHO) system right now? N/A

4) What is not working well in the BHO system? N/A

5) What is working well with RCCO and BHO collaboration right now? N/A

6) What is not working well with RCCO and BHO collaboration right now? N/A

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1] N/A

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☒	☐	Medicaid still has not released new coverage rates
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care? N/A

10) Please share any other general advice or suggestions you may have about behavioral health integration.

N/A

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

A collaboration go ensure clients are being well cared for and services are being given without duplication.

b. How should RCCOs prioritize who receives care coordination first?

c. How should RCCOs identify clients and families who need care coordination?

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today? N/A

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	
Health literacy	☐	☐	☐	
Housing	☐	☐	☐	
Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	
Transportation	☐	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	Coordinate care? No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

    a. What is the PMPM cost for providing care coordination services?

    b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

    a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

Currently we only utilize eligibility and billing services.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

I think this is a reasonable option. Proper training could allow us to utilize current employees.

47) **Community Health Worker reimbursement**. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☒
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 008

Accepted by: KJDW

Notes: Applied standard formatting

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Click here to enter text.
Location: City, County, State.

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Click here to enter text.
Location: City, County, State.
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☒ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☒ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
I have been involved for 2+ years. Attend all meetings and a representative for our Safety Net Clinic. (not NCQA)

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Committee involvement and liaison at state and local level. Oversee ACC regulation, clinic billing, clinic payments, care coordination.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☒ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

    - Finding medical homes for its clients.

2) What is not working well in the ACC Program?

    - Rules of Enhanced PCMP Care have created barriers for providers. Trying to follow the exact wording of an NCQA facility is wrong and it cuts out a lot of providers with these 9 rules.
        - For instance, regarding #1, dictating set times for which a provider can offer extended hours can be difficult financially for the smaller practices, safety nets and rural settings. The ACC should allow creativity by the provider, not the NCQA standards. With these strict rules, a provider that is open during the lunch hour or even has extra providers on a schedule to triple book one day would not meet the standards for expanded hours.
    - Changes in providing data metrics to ACC. Understand the state wants a clearer picture, but care management and care coordination can be subjective. Assuming that all participants on these forms are licenses and asking for FTE's is not reality. We have volunteers, part time staff and many UNLICENSED workers that provide this service and the metrics forms dictate otherwise.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

    The efforts to integrate care in the clinic setting have been enormously helpful. The integration movement in the clinic has been huge and embraced by all.

4) What is not working well in the BHO system?

    a. Strict licensing rules of 3 yrs of practice has caused hardship to hire a BH Provider! So many have come from a mental health center and licensing is under the facility. When the BH staffer leave that setting to come to a clinic, they have no individual years of licensing. Our clinic was not able to hire anyone.

    b. Increase the reimbursement dollars to encourage providers and clinics to hire.

S) What is working well with RCCO and BHO collaboration right now?

    See above

6) What is not working well with RCCO and BHO collaboration right now? See above. Watch the creations of overstock of rules that non-bh providers are facing in the ACC now!

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

See above answers

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☒	☐	Strict rules for licensing of 3 yrs is impossible for individuals out of MH Centers.
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☒	☐	Should be equal to other non-BH provides
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☒	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☒	☐	Keep getting more strict, less freedom for provider to create and be independent
Staff capacity	☒	☐	Cost to hire is difficult
State/Federal rules or reporting requirements	☒	☐	Burdonsome
Technical resources / data sharing	☒	☐	COHRIO doesn't seem to be working, Medicaid data is old.
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

The ACC Program is a great idea and generous to the primary care provider!

However, we will never get clinics or providers on board that are not federal clinics because of the strict rules of the ACC for membership and metrics. For instance, we checked all of south metro area of Denver to find providers accepting new adults >18 if they would accept a new Medicaid patient. Only 10 practices exist and 4 of them are federal funded clinics!

To entice providers to participate is not going to happen by dictating Enhanced PCMP Care standards that mimic a NCQA, by asking for FTE's and licenses on our enhanced care management programs is alarming.

Sell the mission of the ACC/RCCO to a provider, tell him/her of the reimbursement and allow the provider the opportunity to create that vision based on the mission. Medicaid is the least paying, yet has the most rules. The easy way out of how to measure success by ACC and State is not to be mimicking an FQ as it is exclusionary.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

- There is a shortage of licensed counselors that will take Medicaid that aren't working in a mental health clinics and we need to make it easier to get individuals credentialed so they can work elsewhere. 3 years on a individual is pretty much impossible as they all come from a MH Clinic with no individual licensing.
- Increase the reimbursement to entice a hire by a primary provider.
- Please see prior comments in other sections.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

Our Clinic defines it as managing the care of a patient or patient population that needs assistance with a positive outcome to their health. It's important to recognize that care coordination can be medical or non-medical.

b. How should RCCOs prioritize who receives care coordination first?

The RCCO's set standards for the provider focus, but the RCCO must be careful of the burden of continuing to change them or add to them. You have to focus on your areas of need first. Focusing on high ER use has to be a priority for all of us and encouraging a patient to engage in a medical home. Giving an annual well visit is also critical to the program.

Addressing the patients bio, social and psychological character and how it effects their health must be part of the care coordination. What are the barriers that are keeping that patient from having excellent health?

c. How should RCCOs identify clients and families who need care coordination?

Have the standards and metrics to match them..

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

It must be accepted that some of this is subjective for a clinic. Metrics are important and claims show a picture. However, creating too many rules and requirement on reporting will not improve the care and will not assist the state in getting a bigger picture.

Slow down on the barrage of item to care coordinate. i.e. well care, er visits, depression screens are quite enough. Asking for diabetes, a1c, age driven metrics is too much. Ask for 1-2 things and see the results adding more metrics and items to care coordinate is too soon and will confuse providers on where to focus.

12) What services should be coordinated and are there services that should not be a part of care coordination?

It must be accepted that some of this is subjective for a clinic. Metrics are important and claims show a picture. However, creating too many rules and requirement on reporting will not improve the care and will not assist the state in getting a bigger picture.

Slow down on the barrage of item to care coordinate. i.e. well care, er visits, depression screens are quite enough. Asking for diabetes, a1c, age driven metrics is too much. Ask for 1-2 things and see the results adding more metrics and items to care coordinate is too soon and will confuse providers on where to focus.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs? A. The hospitals do not tell us when a patient is in their hospital. They also encourage ER use with signage and advertising.

B. COHRIO seems as if it will not work to address all of this need for communication with a provider and we need some sort of real time communication

C. Claims bases data provided to providers may be old for addressing an individual, but is very helpful to get a general picture.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

Navigation to address non medical barriers to health care with

Dental is a huge addition

Provider and assistant outreach

Behavioral health assistance

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

There are hundreds of resources and organizations available everyday to assist with care coordination.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

Allow for creativity and less rules and use of outside ACC resources. It's so subjective and not everything can be measured.

d. What are the gaps in care coordination across the continuum of care? Real time information and lack of ways to communicate that information

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	Should the RCCO have a role? No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☒	☒	No. there are resources and don't duplicate. Also rcco's need to be careful of having that information that can be private.
Affordability (assistance with prescriptions or co-pays)	☐	☒	☒	Don't duplicate what is clearly out there.
Daycare / childcare	☐	☒	☒	Don't duplicate what is clearly out there.
Economic stability & employment	☐	☒	☒	Don't duplicate what is clearly out there.
Education	☐	☒	☒	Don't duplicate what is clearly out there.
Environment	☐	☒	☐	
Food access / nutrition	☐	☒	☒	Don't duplicate what is clearly out there.
Health literacy	☐	☒	☐	
Housing	☐	☒	☒	Don't duplicate what is clearly out there.
Language or translation services	☒	☐	☒	It's a problem to not have a free language line.
Literacy	☒	☐	☐	Don't duplicate what is clearly out there.
Transportation	☒	☐	☒	Don't duplicate what is clearly out there.
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	Coordinate care? No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	
Certified Addiction Councilors	☒	☐	
Certified Nurse Midwives	☐	☒	
Community Health Workers	☒	☐	
Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☒	☐	
Licensed Mental Health Counselors	☒	☐	
Licensed Professional Counselor	☒	☐	
Masters of Public Health	☒	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	
Nurse Practitioners	☒	☐	
Patient Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☒	☐	
Psychiatrists	☒	☐	
Psychologists	☒	☐	
Registered Nurses	☒	☐	
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	
Other	Again do not dictate who can care coordinate, but rather embrace all		

types. This list is an example of all care givers that can effect barriers to health care and assist in care coordination. The provider is more focused on medical these days while others are assisting in the coordination.

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☒	
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☐	☒	
Children involved in the foster care system	☐	☒	
Children with a chronic illness	☒	☐	Many are very ill and cant be quantified in ACC categories for specific care.
Children with a serious emotional disturbance	☒	☐	Many are very ill and cant be quantified in ACC categories for specific care.
Children with medical complexity	☐	☒	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	Many are very ill and cant be quantified in ACC categories for specific care.
Transition-age adolescents	☐	☒	
Parents and families	☐	☒	
Pregnant women	☐	☒	
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☐	☒	
Adults with a chronic illness	☐	☒	
Adults with a behavioral health diagnosis or substance use disorder	☒	☒	Many are very ill and cant be quantified in ACC categories for specific care.
Clients involved in the criminal justice system	☒	☒	Many are very ill and cant be quantified in ACC categories for specific care.
Clients with a disability	☐	☒	
Clients in a nursing facility	☒	☐	Many are very ill and cant be quantified in ACC categories for specific care.
Elderly clients	☒	☐	Many are very ill and cant be quantified in ACC categories for specific care.
Frail elderly clients	☒	☐	Many are very ill and cant be quantified in ACC categories for specific care.
Clients in palliative care	☒	☐	Many are very ill and cant be quantified in ACC categories for specific care.
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system? They need to receive RCCO standards of care and navigation.

Case manager at RCCO should follow these cases and alert providers only when something is needed.

19) How should care coordination be evaluated? How should its outcomes be measured?

Be careful of the NCQA guide! Enhanced PCMP care program is built for federally qualified and funded clinics. The standards do not necessarily afford a provider, rural clinic or urban safety net clinic to financially meet these standards. Your average provider can only handle so much in his/her clinic and outside resources must be used and therefore can't be judged as not care management.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

We don't receive that much money. This cost also cannot be measured as entire staff and also possibly volunteers could be involved in 1 case.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

??

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

NO! How can you force providers to hire these people? Again this assists is the FQ that can afford to hire care coordinators. Don't dictate more ratios and rules.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☒
26-50	☐
51-100	☐
101-200	☐

201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

ER Visits

Annual Well Visits with Depression Screens

Behavioral care in integrated setting

Dental Care-annual cleaning

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Slow down! Understanding the state wants more data to show the ACC is working, but am feeling that it's becoming rule laden and too many items to care coordinate. Also accept that care coordination at times can't be measured and a simple contact is subjective and could save a life.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

RCCO's should have more standards that are across the board. We feel that fiefdoms have been formed in all the RCCO's. Let's make Denver 5 more accountable in these issues as they are still turning patients away.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Newly insured clients are bombarding ERs because there are not enough PCP's to take them. Why have all these rules when this issue is simply not addressed.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

Disagree as I think they all should have clear standards across all RCCO's with few differences. Just because a provider crosses path with a patient from a different RCCO should not give them reason to shop another RCCO based on reimbursement or better stats for shared savings. Every FQ would join the best one with the best shared savings. Just has potential to not be a good idea.

27) Should the RCCO region maps change? Why or why not? If so, how?

No comment

28) Should the BHO region maps change? Why or why not? If so, how?

Yes! They should be the same as the RCCO's.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

I don't understand or know enough what this means to comment.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

I would ask that all of these prior comments be shared. Standardize the RCCO rules, have less metrics. This is not a public health experiment.

However, a forward thinking clinic receives the payment and may have a robust PCMP Medical Home and offers navigation and care coordination, yet receives the same payment for a clinic that may not be embracing the same standards.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

Medicaid now has better benefits than my own private insurance plan offered by my employer and I worry where this will all go with more increased benefits. Where will the money come from to sustain all of this?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

No.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

Only assist if unattributed and we must be careful of farming off others. There has to be some neutrality with providers.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

Patience! Realize you have a shortage of providers and focus on that, then the results. HCPF sometimes wants results and lower stats, but when they pressure the ACC to improve stats, the ACC create more rules and more metrics.

However the ACC's have a lot of money and I am concerned about their oversight, their budgets and hope they are watched as closely in audit by the state as the provider seems monitored by the ACC.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

Standards should be set by the State with oversight. Limit arm of ACC's to act alone and standardize rules for each RCCO.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

None

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Follow the rules!

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

Nothing

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

Reporting of metrics, sharing in savings

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

By not taking assuming all providers are in FQ's and follow NCQA rules. Local programs and individual issues always exist and we can't be in one pot all the time. Again, more general standards for providers and more standardization for RCCO's.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

The current community type meetings in the RCCO's seems to be working.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population? There are shortages of providers and specialists across the board! Unless we simply give up and have giant clinics that take Medicaid, we have to make participation a priority. The same can be said for dental and BH providers.

a. If no, what are the gaps?

Very few providers accept Medicaid. They may be credentialed, but they are not accepting new patients. Hospitals need to be more accountable and assist in care coordination and promoting medical homes. They also can heavily influence specialist at their hospitals to "play" in the Medicaid world. There are also very few independent Urgent Care's that accept Medicaid, which is a problem in after hours care and encourage hospital ER use.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

I'm not sure that's an issue as we see very few. Childrens Hospital pretty much has a lock on that area for the youngsters and are there medical home. A lot of these patients are so diabled and have so many issues a primary provider can't be appropriate as there's more need for special care.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

More accountability in stopping preventable visits by navigation and encouraging use of a medical home. They encourage ER visits by marketing wait times. They also have got to join together and communicate today with providers and all hospitals on patients in their hospitals and the patient using multiple facilities.

b. What role should pharmacies play in the next iteration of the ACC Program?

No comment

c. What role should specialists play in the next iteration of the ACC Program?

We need to encourage participation! Similar to a PCMP, we need to give them incentive pay to be part of the ACC. Let them share in cost savings, i.e. keeping er visits low. We have specialists that are more willing to care for someone for free than take a Medicaid patient. Why? Low reimbursement and afraid if they take one, they'll all come.

d. What role should home health play in the next iteration of the ACC Program?

It's covered and not sure what else to say here.

e. What role should hospice care play in the next iteration of the ACC Program?

None really.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

None, it's too much right now and a burden. Slow this part down.

g. What role should counties play in the next iteration of the ACC Program?

None. They seem pretty busy already.

h. What role should local public health agencies play in the next iteration of the ACC Program?

If they are able, let them be a PCMP and share in incentive programs.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

I think I have addressed multiple times in prior comments.

45) How can RCCOs help to support clients and families in making and keeping appointments?

Let the providers handle and currently Healthy Communities already assists us in RCCO 3.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

Yes, it is the only way this whole care program can work! However, billing for their care doesn't seem okay with me. But accepting them as caregivers in the total picture of assisting the PCP with care coordination is important and should be measured, but not billable.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☒
On staff (salary) at RCCO	☒
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

It should be the same as any BH standards, especially related to well care.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

Accepting of all cultures, cultural situations and their norms and meeting that in a medical setting.

b. What RCCO requirements would ensure cultural competency?

As a reporting entity. Not sure how a RCCO could be involved unless someone was judged or turned away.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

I believe most professionals in the health care industry are aware and have experience to address. We don't need a state or ACC making sure of that, but perhaps rather address with any reportable incidents of prejudice toward a culture.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Offer a free Language Line.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

Yes.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Find some providers to join! Again the state and ACC are some focused on outcomes that recruitment got skipped. Perhaps no one cares about it, but if we don't address, we graduate to large federally qualified health clinics for the underserved only and keep them separate. I don't think anyone wants that, so we need to get providers on board. Thus the rules and metrics need to be minimal. When you get a population, then start to measure.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☐	☒	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☒	☐	☐	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☐	☒	☐	☐
Provide registries	☒	☐	☐	☐
Offer client reminders	☐	☒	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☒	☐	☐	☐
Supply behavioral health surveys	☒	☐	☐	☐
Supply other self-screening tools	☒	☐	☐	☐
Administer behavioral health surveys	☒	☐	☐	☐
Administer other self-screening tools	☒	☐	☐	☐
Prepare client action plans	☐	☒	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☒	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☒	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☐	☒	☐	☐
Provide standing pharmacy order templates	☐	☒	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☐
Provide directory of other resources	☒	☐	☐	☐
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others	Please don't make any of these items required, but rather support tools.			

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

The role of the RCCO is to coach and educate that. But, easy on requirements and respect limited staff and time. This is not their only patient roster!

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

Look at individual movement rather than only the RCCO group.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

Why, that is already done. It's seems like the Dept wants ACC to become a separate entity. These things exist already is so many settings, why duplicate?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

They are fine. However, clinics that make patients wait for days or months on end to get well care or even sick care should not be reimbursed same as the other PCMP that is giving more immediate care. Let the patient go elsewhere. Spot audits and patient reporting should happened and lowered pay or some sort of warning should happen.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

No never! Care suffers and there's no incentive to do better other than see as many as you can. Certain big city Clinics are a current prime example of collecting large numbers of patients and not providing a medical home that meets the Triple Aim of health care.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Yes they do and it is subjective, but can be done through general metrics.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

YES!

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

They should distribute the pay with oversight of audit by department

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

It sounds like this RFI shows a theme of the dept and ACC's becoming license capitated free standing clinics with less embracing of the small clinic and primary provider groups. I'd like more of a definition of what the dept wants as I am getting mixed messages on future of providers in various settings. What does the state want as there are some major driftings towards FQ. If that's the case, we need to be up front and discuss the future.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

General measure where all can participate would be best. Lower ER, high numbers of well visits, etc.

We need to get support in having people use the provider or clinic as their medical home and communicate that to clients and hospitals. Also general public messaging would assist. There's simply no support with this.

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	
SF-12 Health Survey	☐	☐	I don't know what that is.
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☒	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

I don't know. Surveys perhaps and focus groups. Census work.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

Yes!

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐

None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☒
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Yes.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

No.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

Monthly or quarterly is financially helpful to us.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒

Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

We measure success by finding solutions or improving health in individual cases. It's impossible for us to measure success on total numbers served.

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☒	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☒	☐
Shared decision-making tools	☒	☐
Telemedicine software	☐	☒
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☒	☐	☐	☐
Health risk assessment software	☒	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☒	☐	☐	☐
Patient education wellness tools	☐	☐	☐	☒	☐
Provider/case manager directory	☐	☒	☐	☐	☐
Shared decision-making tools	☐	☒	☐	☐	☐
Telemedicine	☐	☐	☒	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Cost and time. Plus COHRIO is not going to be the answer.

81) How can Health Information Technology support Behavioral Health Integration?

Exact same as non-BH. Most EMR's accommodate BH nicely.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

I think we have enough data, but hospitals need to share with us.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

No. I think it is already being developed by RCCO's, but a care management tool should be customized by the provider and their team based on ACC/RCCO goals and standards.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

Great idea for illnesses perhaps

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

We have our own staff checking the booklet to find out if they are accepting new patients. We don't care if they are credentialed, it's if they are taking patients.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

More timely information.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

All EMRs are slightly differentt. All of of EMR's do this these data reporting and other parameters, so please be careful of creating roadblocks when we have systems that address it.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

We have our own IT department

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

It needs to work! CORHIO is just not integrated yet and it's not helpful in the big picture until all participate. Many providers don't have software of data to consider it yet.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 009

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Doug Bonino
Location: Aurora, Arapahoe, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Continuum of Colorado
Location: Aurora, Arapahoe, Colorado
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
X Other (please describe): HCBS Waiver provider

Are you currently involved in the ACC program?

☐ Yes
☐ No
X I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
no

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
HCBS Waiver Provider with clients who have a Developmental or Intellectual disability

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
X/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

* We are a provider of intensive ABA services for children with autism and other developmental disabilities, and as such our services have not been covered by Medicaid, nor do we work within ACC currently. We are responding in the hope that ABA services, provided board certified behavior analysts, will become a more accessible option for families as part of behavioral health services, when such support is determined to be medically necessary.

2) What is not working well in the ACC Program?

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	X	☐	Because ABA services have not been covered for individuals with autism (outside of limited waiver options), we are usually consulted or aware of physical health services.
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	X	☐	Not being able to anticipate coverage for those needing intensive behavioral intervention (ABA) makes it difficult to staff appropriately.
State/Federal rules or reporting requirements	X	☐	State rules not consistent with CMS guidelines regarding coverage of individuals with autism.

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Consider ways to make quality behavioral services, such as ABA provided by Board Certified Behavior Analysts, more accessible. If necessary, Colorado could follow the direction of many other states in creating a state licensure program for BCBA's, or could instead choose to recognize the national certification as an acceptable indicator of expertise (which has been the finding of courts in applicable law suits against private insurance companies.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

b. How should RCCOs prioritize who receives care coordination first?

c. How should RCCOs identify clients and families who need care coordination?

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

Response from the HCBS-DD residential provider indicates Medical care with the primary physician and care from the behavioral team being done by residential management

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different? For clients served in the HCBS-Dd waiver services are coordinated through the residential agency and the case management department of the CCB

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

Have communication with the residential agency – or even better, have the RCCO contract with the residential agency to provide the care coordination since they are already doing it and that way you can avoid duplication of efforts.

Similarly have the RCCO contract with the CCB Case Management department for those individuals where they are already engaged and involved (and there is not a medical provider already delegated as the care coordinator). This avoids unnecessary duplication and more people in the customer's life added no extra value assuming the customer doesn't want more people to have to deal with.

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

The designated core coordinator should have a role in the areas below. If the RCCO – for reduced duplication contracts this role out, then their role becomes one of oversight to verify that the coordination is occurring as intended.

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma		x☐	X	See comment above
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	See comment above
Daycare / childcare	☐	☐	☐	See comment above
Economic stability & employment	☐	☐	☐	See comment above
Education	☐	☐	☐	See comment above
Environment	X	☐	X	See comment above

Food access / nutrition	☐	☐	☐	See comment above
Health literacy	☐	☐	☐	See comment above
Housing	X	☐	X	See comment above
Language or translation services	☐	☐	☐	See comment above
Literacy	☐	☐	☐	See comment above
Transportation	☐	☐	☐	See comment above
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Difficult to answer as these are all specific to the individual and their needs and preferences. If the idea is to determine how to provide for the highest level of coordinated care for the individual then given all of the systems in involved in their life there should be one lead care coordinator that determines how this should occur.

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	X	☐	Medical Care
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	

Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Any of the above if the client needs those supports		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	X	
Children	☐	X	
Children who are healthy, but in socially-complex environments	X	☐	Social Service involvement if necessary for health and safety
Children involved in the foster care system	X	☐	Social Service involvement if necessary for health and safety
Children with a chronic illness	X	☐	Social Service involvement if necessary for health and safety
Children with a serious emotional disturbance	X	☐	Social Service involvement if necessary for health and safety
Children with medical complexity	X	☐	Social Service involvement if necessary for health and safety
Children or youth with a behavioral health diagnosis or substance use disorder	X	☐	Social Service involvement if necessary for health and safety
Transition-age adolescents	☐	X	
Parents and families	☐	X	
Pregnant women	☐	X	
Adults	☐	X	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	X	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 010

Accepted by: KJDW

Notes: Standard cover sheet added; formatting standardized

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

ACC Request for Information

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: DAVID B. ROOS, M.D.

Location:

923S CROWN CREST BLVD, #100

PARKER, CO 80138

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: CROWN POINT PEDIATRICS

Location: PARKER

☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty:
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

As a provider

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

I have been a Medicaid provider for 32 years.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☒ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

Are you currently involved in the ACC program?

☐ Yes
☒ No
☐ I don't know

If you answered "yes" above, how long?

☒ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.

- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.
    - So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
    - Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
    - There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within

the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing 5DAC data is just one way to understand the activities within a medical home. 5DAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:

a. Assistance with finding a behavioral health provider for patients
b. Telephone consultation by a child psychiatrist to primary care providers

We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Core Coordination

Question 12) What needs for children/families should be coordinated in medical homes and are there services that should not be a part of care coordination by the pediatric and family medical home

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Our medical home relates to multiple RCCOs and we want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we could receive a pmpm from all of them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where should care coordination be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and

understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill? The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another

RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County
- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

Payment Structure and Quality Monitoring

S9) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes

to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

- Since children are the majority and give the best chance of truly improving health and wellness, KPIs need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully. Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of

children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and provider from medical homes to develop a vetting process that will enable HCPF and RCCOs to trust medical home self-reported real-time data.

- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd.
  Appropriate child health measures could be selected from the following measures :
  - Well child visits appropriate for age
  - Developmental screening by three years of age
  - Teen depression screening
  - Complete immunization status by age two
  - Post-partum depression screening rate for mothers of newborns by age 4 months
  - Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
  - Patient (or family) satisfaction ratings
  - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 011

Accepted by: KJDW

Notes: Standard cover sheet added; formatting standardized

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

ACC Request for Information

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Centennial Pediatrics, PC

Location: 15464 E. orchard Road

Centennial, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization:

Location:

☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty:
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Involved in two ACC – Colorado Access and PHP

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Pediatric medical provider.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☒ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Are you currently involved in the ACC program?

Please feel welcome to describe why or why not using the space below.

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☒ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now. – This has been a significant improvement but I see little benefit in participation with the ACC – they provide little care coordination for my patients

- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.
    - So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
    - Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
    - There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family. HUGE problem still in the system. We have had a large problem with my patients being assigned to another provider. We have also had a significant problem with my patients showing ineligible on the website but calling Medicaid and being told "I am not sure why your provider is saying that you are elibigile it is their problem" This puts a signficiant "blame" on us when the eligibility website clearly states they patient is ineligible and creates a us vs them and not making the provider on the same team as Medicaid.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing SDAC data is just one way to understand the activities within a medical home. SDAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new

technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients
  b. Telephone consultation by a child psychiatrist to primary care providers
  We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Care Coordinotion

Question 12) What needs for children/families should be coordinoted in medical homes ond ore there services thot should not be o part of core coordinotion by the pediotric ond family medical home

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

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them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where should care coordinotion be done? Care coordination is best done in the medical home. In our experience when I have called the RCCOs for care coordination NOTHING has been done and they are not helpful at all. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

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There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients or not – if a provider feels they can handle these services they should be given the management fee. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

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Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

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- Since children are the majority and give the best chance of truly improving health and wellness, KPIs need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully. Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

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- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd.
  Appropriate child health measures could be selected from the following measures :
  - Well child visits appropriate for age
  - Developmental screening by three years of age
  - Teen depression screening
  - Complete immunization status by age two
  - Post-partum depression screening rate for mothers of newborns by age 4 months
  - Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
  - Patient (or family) satisfaction ratings
  - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 012

Accepted by: KJDW

Notes: Standard cover sheet added; formatting standardized

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

ACC Request for Information

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Dawn M Dycus, MD

Location: 183 S. 18th Ave, Brighton CO 80601

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Brighton Pediatrics

Location: same

☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Pediatrics
  ii. Area of practice: private practice
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

I have not had any interaction with RCCOs that I am aware of

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

I am a provider in an office that accepts Medicaid patients.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☒ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Are you currently involved in the ACC program?

☐ Yes
☐ No
☒ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.

- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.
    - So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
    - Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
    - There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. So, the RFP should ask how RCCOs intend to deal with this.

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing 5DAC data is just one way to understand the activities within a medical home. 5DAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients
  b. Telephone consultation by a child psychiatrist to primary care providers
  We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Care Coordination

Question 12) What needs for children/fomilies should be coordinated in medical homes ond ore there services that should not be o part of care coordinotian by the pediatric and fomily medicol home

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Our medical home relates to multiple RCCOs and we want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we could receive a pmpm from all of them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where should care coordinotion be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill? The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care

coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

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- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

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Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 013

Accepted by: KJDW

Notes: Standard cover sheet added; formatting standardized

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

ACC Request for Information

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:	If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:
Name: Joe Craig, MD, FAAP President, Colorado Chapter, American Academy of Pediatrics Location: Lakewood, CO	Name of organization: Colorado Chapter, American Academy of Pediatrics Location: Littleton, CO x Please check if you are answering on behalf of this entity

This document represents the answers to this RFI from the Colorado Chapter of the American Academy of Pediatrics

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client

☐ Client's family member

☐ Client advocate

☒ Medical provider / PCMP / other provider

i. Type or specialty:
ii. Area of practice: Click here to enter text.

x Provider advocate (e.g. medical society)

☐ Potential bidder for RCCO contract

☐ Behavioral Health Organization

☐ Data or HIT entity

☐ Foundation

☐ Educational or research institution

☐ Another public or private program

☐ Legislator or elected official

☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Click here to enter text.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely

☐ Likely

☐ Reserved (waiting to see the RFP)

☐ Unlikely without significant changes

☐ Will not seek to participate

☐ N/A

Please feel welcome to describe why or why not using the space below.

Are you currently involved in the ACC program?

☐ Yes

☐ No

☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year

☐ 1-2 years

☐ 2-3 years

☐ 3-4 years

☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.

- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.
    - So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
    - Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
    - There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within

the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's

must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing 5DAC data is just one way to understand the activities within a medical home. 5DAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients
  b. Telephone consultation by a child psychiatrist to primary care providers

We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Care Coordination

Question 12) What needs for children/families should be coordinated in medical homes and are there services that should not be a part of care coordination by the pediatric and family medical home

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Our medical home relates to multiple RCCOs and we want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we could receive a pmpm from all of them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where should care coordination be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill? The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.
- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.
- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.
- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They should include PCMPs in developing those criteria.
- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.
- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County

- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes

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  - Documentation of QI projects

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- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 014

Accepted by: KJDW

Notes: Standard cover sheet added; formatting standardized

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

ACC Request for Information

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Lowry Pediatrics

Location: 8190 E 1st Ave #100

Denver, CO 80230

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization:

Location:

☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty:
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Click here to enter text.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☒ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.

- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.
    - So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
    - Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
    - There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within

the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing SDAC data is just one way to understand the activities within a medical home. SDAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients

b. Telephone consultation by a child psychiatrist to primary care providers
We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Care Caardinatian

Questian 12) What needs for children/families should be caardinated in medical hames and are there services that shauld nat be a part af care caordination by the pediatric and family medical hame

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Our medical home relates to multiple RCCOs and we want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we could receive a pmpm from all of them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where should core coordinotion be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill? The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.
- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.
- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.
- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County
- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high

performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

- Since children are the majority and give the best chance of truly improving health and wellness, KPIs need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully. Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and provider from medical homes to develop a vetting process that will enable HCPF and RCCOs to trust medical home self-reported real-time data.

- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd.
  Appropriate child health measures could be selected from the following measures :
  - Well child visits appropriate for age
  - Developmental screening by three years of age
  - Teen depression screening
  - Complete immunization status by age two
  - Post-partum depression screening rate for mothers of newborns by age 4 months
  - Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
  - Patient (or family) satisfaction ratings
  - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

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69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

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None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 015

Accepted by: KJDW

Notes: Standard cover sheet added; formatting standardized

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

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THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

ACC Request for Information

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Brad Kurtz

Location: Physician Advanced Pediatric Associates

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization:

Location:

☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty:
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Click here to enter text.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

Are you currently involved in the ACC program?

☐ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.

- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.
    - So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
    - Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
    - There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within

the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing 5DAC data is just one way to understand the activities within a medical home. 5DAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:

a. Assistance with finding a behavioral health provider for patients
b. Telephone consultation by a child psychiatrist to primary care providers

We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Care Coordination

Question 12) Whot needs for children/fomilies should be caardinated in medicol homes and are there services that should not be o port af care coordinotion by the pediatric and family medical home

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Our medical home relates to multiple RCCOs and we want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we could receive a pmpm from all of them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where should care coordination be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill? The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.
- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.
- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.
- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County
- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

- Since children are the majority and give the best chance of truly improving health and wellness, KPIs need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

<u>There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully.</u> Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation

among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and provider from medical homes to develop a vetting process that will enable HCPF and RCCOs to trust medical home self-reported real-time data.

- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd.
  Appropriate child health measures could be selected from the following measures :
  - Well child visits appropriate for age
  - Developmental screening by three years of age
  - Teen depression screening
  - Complete immunization status by age two
  - Post-partum depression screening rate for mothers of newborns by age 4 months
  - Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
  - Patient (or family) satisfaction ratings
  - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO

programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 016

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: **Becky Otteman**
Location: **La Junta, Colorado**

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: **Southeast Health Group**
Location: **Six Southeastern Counties**
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: **Behavioral Health**
  ii. Area of practice: **Mental Health, SUD, Primary Care & Wellness Services**
☐ Provider advocate (e.g. medical society)
☒ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☒ 3-4 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Southeast Health Group is both a provider and partner/owner of Integrated Community Health Partners (ICHP) the Region 4 RCCO.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Behavioral Health provider for Baca, Bent, Crowley, Kiowa, Otero, and Prowers Counties since 1957.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- **"All healthcare is local" and that is what is working best. The network of providers developed at the local/community level for individuals to access for care has expanded across our 6 counties.**
- **Care coordination that is person-centered and done at the right time and right place for the individual which is when they enter the office for care and in their own community.**

2) What is not working well in the ACC Program?

- **The cost and quality of care provided will not get better until payment reform picks up speed in the state and transitions away from a fee-for-service system. KPIs have only had a minor impact on the overall cost of care. A risk-based global payment model that forces providers to focus on the Triple Aim (better care, higher quality, and lower costs) is the direction that the next phase of the ACC program needs to go. This is a huge change, thus it may have to be transitioned in incrementally over a definitive period of time.**

3) What is working best in the Behavioral Health Organization (BHO) system right now?

- **Our BHO has been able to efficiently and effectively "bend the cost curve" by controlling costs, managing provider risk, and providing access to more individuals in our six counties that need our services.**

4) What is not working well in the BHO system?

- **Encounters. We (the Behavioral Health Providers and OBH and HCPF) talk about a person-centered approach to care that is focused on value and outcomes, yet we still have to be concerned with counting widgets/encounters. This practice of counting encounters is from the Fee-For-Service system which is what we should be moving away from if we are serious about payment reform in the State of Colorado.**

5) What is working well with RCCO and BHO collaboration right now?

- **Local partnerships that have the flexibility to make an impact on the physical and behavioral health care of our citizens. Solutions to issues are developed and implemented at the local level.**

6) What is not working well with RCCO and BHO collaboration right now?

- **As behavioral health providers we still do not have access to the SDAC system. This impedes our ability to more effectively coordinate care.**
- **Payment reform – moving away from FFS and to a global budget – is not happening. In this next phase of the ACC contract that needs to happen.**

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- **Since this RFI is all about the next phase of the ACC, then it only makes sense that rewarding bidders for integration should be a major focus of the ACC. Recognizing that providers are at different steps on the ladder towards integration, a system that recognizes and rewards at the different levels and continued movement towards full integration should be part of the ACC. Integration should be done not just with client care, but also with provider data, and funding/financing streams.**

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	**Fragmented funding streams with too many meaningless measurement and reporting requirements.**
Community Behavioral Health Services Rule	☒	☐	**Rules and regulations need to be streamlined. Over-regulation adds a complexity to the system that fragments it and forces providers to focus on the multiple regulations that they will be audited on rather than person-centered integrated care.**
Covered diagnoses list	☒	☒	**I marked yes and no because it really depends on the situation at hand. It would be easier to integrate if all of the diagnoses and codes were open to us, however the covered diagnoses list does not cause huge problems for us at this time.**
Different behavioral / physical health reimbursement	☐	☒	
Institutions for Mental Diseases exclusion	☒	☐	**Our 1915(b)(3) waiver does offers us some help in this area through our Medicaid Managed Care program.**
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	**Again, regulations need to be streamlined and re-aligned so there is one set of rules, reporting, and financing. The regulatory differences between agencies are a huge barrier to integration because many of the rules and reporting requirements are in direct competition or at odds with each other. This fragments the system and as long as there is fragmentation it will hamper any integration efforts.**
PCMP financing structure	☐	☒	**Behavioral health agencies are not recognized as PCMPs so I can't respond to this with any informed intelligence.**
Per-member per-month amount	☐	☒	
Physical space constraints	☐	☒	

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Privacy Laws (HIPAA, 42 CFR)	☒	☐	**HIPAA is not a problem, but in our SUD division the struggles with 42 CFR keeps us from coordinating care and integrating in the way that is best for our communities.**
Professional / cultural divisions	☒	☐	**Many physical health providers still do not believe that behavioral health is "health".**
RCCO or BHO contracts	☐	☒	
Staff capacity	☒	☐	**Workforce issues are prevalent throughout the whole State, but even more so in our six rural and frontier counties where poverty is the highest. Most clinical providers (both physical and behavioral health care) do not want to live in a rural/frontier environment, nor do they understand it.**
State/Federal rules or reporting requirements	☒	☐	**Again, rules and reporting requirements all need to be aligned.**
Technical resources / data sharing	☒	☐	**As I said earlier, behavioral health still does not have access to the SDAC.**
Training	☐	☒	
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

- **The community based behavioral health providers have supported and continue to support the six levels of integration as outlined by SAMHSA. You can find these on their website at www.samhsa.gov titled A Standard framework for Levels of Integrated Healthcare.**

10) Please share any other general advice or suggestions you may have about behavioral health integration.

- **Behavioral health integration needs to be bi-directional. At Southeast Health Group we have opened our own physical healthcare clinics on-site at 2 of our 8 locations. At these sites our physical health care providers work alongside our mental health and substance use disorder providers. They have a formal weekly team meeting to talk about difficult cases and to coordinate care. Referrals from one provider to another are done immediately and when the person is in the doctor's office -- this greatly improves the efficiency and effectiveness of the care which results in high quality outcomes.**

- **In some rural/frontier areas, behavioral health integration does not make sense. For example, in Kiowa County whose county population is approximately 1,200 individuals, it does not make sense to have a behavioral health therapist sitting at the local clinic waiting to see a client. In FY 2012-2013 our therapist that services that county saw a total of 20 unduplicated clients for the whole fiscal year. Instead, the doctor at the clinic is on a first-name basis with our therapist and our therapist goes at least once a week and then as needed to see the clients that need behavioral health services. Emergency services are, of course, available 24/7.**

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

- **Taken directly from the ICHP Care Coordination Metrics Definitions – Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in patient's care to facilitate the appropriate delivery of health care services.**

b. How should RCCOs prioritize who receives care coordination first?

- **Every individual that walks in our doors for services needs to receive care coordination – it should not be done on a prioritized schedule. Thus, we provide care coordination for all of our clients. I don't believe in priority lists because they overlook the needs of those individuals that need the care coordination to help keep them stable so their health issues don't escalate and cause them to need a higher level of care.**

c. How should RCCOs identify clients and families who need care coordination?

- **Again, any individual (and their family members that support them with care) should receive care coordination.**

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

- **If every client receives care coordination there does not need to be a tracking mechanism in place as the client's treatment plan and notes from meeting with the health care provider will indicate the care coordination that is taking place.**

12) What services should be coordinated and are there services that should not be a part of care coordination?

- **All services should be coordinated, especially those services that will directly impact the future health of the client. Public Health is an important component in this respect.**

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

- **Health assessments that include the social determinants of health (as long as the social determinants are impacting the health of the client)**
- **Case management services currently receiving or have received in the past**
- **Care planning as developed and implemented by the patient's integrated team of providers**
- **Care transitions from one level of care to another or from one type of living situation to another**
- **Community resources currently used by the client**
- **Specialty providers the client has seen or is currently seeing**

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

- **Care coordination is being provided by everyone that deals with the patient and is done in each agencies own way, with their own forms/templates, definitions, etc. This is a huge problem. There should be one care coordination system that covers all aspects of the client's care and that all providers have access to and can add to in a systematic way that is developed and implemented by the RCCO.**

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

- **As a Medicaid Community Based Behavioral Health Center we are required to do care coordination and have done so for many years. Then in 2011 when the RCCOs started up, all of the sudden we started having problems with care coordination because it was either competing with or in conflict with the care coordination being done through our RCCO.**
- **Because the BHOs and the Behavioral Health Centers have done care coordination for decades it only makes sense that they should have been consulted on their model for care coordination and how it could best be modeled for the RCCOs as they were developing their own care coordination program.**

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

- **Care coordination needs to be done at the RCCO level because that is where the network of providers gets their direction.**

d. What are the gaps in care coordination across the continuum of care?

- **Many doctors and nurses feel that care coordination is not their responsibility and will not come to the table when care coordination needs are being discussed.**

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	Should the RCCO have a role? No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☒	
Affordability (assistance with prescriptions or co-pays)	☐	☐	☒	
Daycare / childcare	☐	☒	☐	**For this item and the next four items, only if the item is having a negative impact on the health of the patient**
Economic stability & employment	☐	☒	☐	⇩
Education	☐	☒	☐	⇩
Environment	☐	☒	☐	⇩
Food access / nutrition	☐	☒	☐	⇩
Health literacy	☒	☐	☐	
Housing	☐	☒	☐	
Language or translation services	☒	☐	☐	
Literacy	☐	☒	☐	
Transportation	☐	☐	☒	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	Coordinate care? No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	In our agency as part of the integration team that meets weekly to deal with client issues and coordinate care.
Certified Addiction Councilors	☒	☐	In our agency as part of the integration team that meets weekly to deal with client issues and coordinate care.
Certified Nurse Midwives	☐	☒	
Community Health Workers	☒	☐	In our agency as part of the integration team that meets weekly to deal with client issues and coordinate care.
Generalists (BA/BS/MA/MS)	☒	☐	In our agency as part of the integration team that meets weekly to deal with client issues and coordinate care.
Health Coaches	☒	☐	In our agency as part of the integration team that meets weekly to deal with client issues and coordinate care.
Licensed Clinical Social Workers	☒	☐	In our agency as part of the integration team that meets weekly to deal with client issues and coordinate care.
Licensed Marriage and Family Therapist	☒	☐	In our agency as part of the integration team that meets weekly to deal with client issues and coordinate care.
Licensed Mental Health Counselors	☒	☐	In our agency as part of the integration team that meets weekly to deal with client issues and coordinate care.
Licensed Professional Counselor	☒	☐	In our agency as part of the integration team that meets weekly to deal with client issues and coordinate care.
Masters of Public Health	☐	☒	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☒	
Nurse Practitioners	☒	☐	In our agency as part of the integration team that meets weekly to deal with client issues and coordinate care.
Patient Navigators	☒	☐	In our agency as part of the integration team that meets weekly to deal with client issues and coordinate care.
Peer Advocates	☒	☐	In our agency as part of the integration team that meets weekly to deal with client issues and coordinate care.
Promotoras	☐	☒	
Psychiatrists	☐	☒	
Psychologists	☐	☒	

Registered Nurses	☒	☐	**In our agency as part of the integration team that meets weekly to deal with client issues and coordinate care.**
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☒	
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☐	☒	**What is the working definition of a "socially-complex environment"?**
Children involved in the foster care system	☐	☒	
Children with a chronic illness	☒	☐	**Home-based services for long lengths of time and coordination with the child's school**
Children with a serious emotional disturbance	☒	☐	**Should be coordinated by the BHO**
Children with medical complexity	☐	☒	**Depends on definition of "medical complexity"**
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	**BHO Coordination**
Transition-age adolescents	☐	☒	
Parents and families	☐	☒	
Pregnant women	☐	☒	
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☐	☒	
Adults with a chronic illness	☐	☒	
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	**BHO Coordination**
Clients involved in the criminal justice system	☐	☒	
Clients with a disability	☐	☒	
Clients in a nursing facility	☐	☒	
Elderly clients	☐	☒	
Frail elderly clients	☐	☒	
Clients in palliative care	☐	☒	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

- **If medical issues are not involved, the RCCO should not be involved.**

19) How should care coordination be evaluated? How should its outcomes be measured?

- **Care Coordination should be evaluated by using measures that look at reduction in use of the emergency room, reduction in overall cost of care, reduction of care duplication, an increase in the quality of care, and an increase in the overall satisfaction with care by the client and an increase in the health status of the client.**

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

- **I cannot answer this question unless I would have access to data that is actuarially sound.**
- **I can speak to the PMPM being changed midstream and how disruptive that is to the overall system from both a business standpoint and a client care standpoint. Once the PMPM is established it should not be changed midstream.**

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

- **Same answer as #20**

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

- **Yes, there should be coordinator to client ratio requirements. Having said that the whole State of Colorado has a huge workforce issue, especially in the rural and frontier areas where our counties are located. There would need to be an exception to the rule for these regions that are not as populated and where resources – including human resources – are scarce.**
- **Also, actuarial soundness would be needed.**

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☒
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

- **By the total reduction in cost of care that is generated from the reduction of unnecessary/duplicative services and the total impact on the overall improved health status of the client.**
- **Metrics that are most important are:**
  a. **Total number of Members receiving care coordination services within a set timeframe.**
  b. **Total number of Members with a completed Health Risk/Care Assessment within a set timeframe.**
  c. **Number of Members with a Care Plan developed and/or updated within a set timeframe.**
  d. **Number of Members who are identified as High ER Utilizers receiving at least one intervention (follow-up service) within a set timeframe from discharge from the ER.**
  e. **Number of Members who are stepping down from inpatient care to a lower level of service.**
  f. **Number of Members referred to other community agencies that supplement patient care.**

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

- **The exchange of information among network providers for different aspects of the patient's care is paramount in the care coordination process. It takes just one provider that ignores this exchange to screw up the whole process for the client and the other providers.**

- **If the care coordination is not helping to bridge the gap between providers and agencies, then it is not being carried out correctly and the whole system needs to be re-evaluated.**

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- **I would add standardized guidelines and protocols to the list above and remove payment methodologies. Payment methodology should look different from one RCCO to another and from one region to another. I think that each RCCO should handle their own payment methodology because the providers in that RCCO region know best what works and what doesn't. The costs of care encountered in the rural/frontier region can be very different from the city or urban area.**

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

- **I think that requiring a bidder to form a relationship with a certain entity will not work. Forced "friendships" never work. It would be better to ask the bidders to list the community relationships that they currently have, both formal and informal, contractual and non-contractual, and what community relationships they wish they could have with what entities and what are the barriers to forming that specific relationship. This will help to understand community strengths and needs more than another mandate or requirement.**

- **There are times when Southeast Health Group does everything in its power to develop a relationship with a community agency, and through no fault of its own, it just does not happen either because of the other agencies philosophy or top leaders lack of initiative. Thus, the reason that requiring bidders to form certain community relationships is not a good idea.**

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

- **Out of our six counties that we cover at Southeast Health Group, 4 of them are frontier and 2 of them are rural according to the Census. We use to have a stable population of approximately 50,000 individuals in those six counties, but our population continues to drop. My point in this is that what is being suggested would not work in our rural/frontier environment as there is not enough volume. Plus, the closest RCCO to us that is not our current RCCO is 2 hours away. Demographically it just wouldn't work.**

27) Should the RCCO region maps change? Why or why not? If so, how?

- **Yes, the State should combine RCCO regions 4 & 7. We already do a lot of work with the providers in the RCCO 7 region through our BHO relationship with Aspen Pointe. Our RCCO 4, ICHP, has had some formal MOUs with RCCO 7 in order for them to utilize a care coordination tool that RCCO 4 developed. Plus, for those of us in rural/frontier Southeastern Colorado most of us go to Pueblo or Colorado Springs for our healthcare and we definitely go to these two communities for any specialty care. I think that there currently is a lot of waste and duplication happening because these two regions are split. Combining them into one RCCO region will help with care coordination and reduction in cost of care because of duplication of services.**

28) Should the BHO region maps change? Why or why not? If so, how?

- **No, they should not change at this time. A new RFP would have to be issued and we are just now settling into our current contract. I have heard side conversations that someday the Department may want to combine the BHOs and RCCOs into one program. If this is true and the Department is working towards this, it would be better to wait until the Department is ready to combine the two entities. I see a change to the BHO regions now as an unnecessary step that would be chaotic not only for the behavioral health agencies, but more importantly for the clients that we serve.**

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

- **Our vendor tells us that 8 months is the minimum, with 10 months being more realistic. I do not know the answers to the other two questions.**

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

- **As I said earlier the streamlining of any/all regulations that the ACC must deal with would help with its effectiveness.**

- **More importantly, risk contracts where the RCCOs manage their own PMPM for care would really help the ACC become more effective through savings generated. We witnessed this happen when the mental health centers went to a Medicaid managed care risk contract and we have seen just how they have been able to bend the cost curve and generate savings through the risk contracts.**

- **Quality measures need to be improved upon for the ACC program. Improvement would impact in a positive way care coordination and access to the specialty care that many of our complex clients need.**

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

- **Southeast Health Group has 2 fully integrated sites that we are not able to access a code for in order to get credit or reimbursed for the physical health services that we provide. So opening up codes for integrated sights would really help.**

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

- **No, the rural/frontier areas of the state cannot handle multiple RCCOs. There is not enough of a population mass to support two. It would be confusing and chaotic for clients.**

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

- **N/A – We are a Medicaid provider.**

34) What role should RCCOs play in attributing clients to their respective PCMPs?

- **RCCOs should be totally in charge of attribution of clients because they know their respective providers best.**

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

- **Nothing at the State level – let the collaboration stay at the regional/local level where it belongs.**

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

- **Nothing at the State level – let the collaboration stay at the regional/local level where it belongs.**

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

- **None – the RCCOs have to handle Medicaid and that is a big enough endeavor in and of itself. Throwing commercial insurance into the mix would be a nightmare!**

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

- **Earlier in this document I mentioned the importance of moving to risk contracts; the Division of Insurance would need to be involved with that.**

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

- **In our rural/frontier environment we have the same people attending the same meetings all of the time. It is extremely difficult to get clients and their families to attend, thus the meetings become just another meeting of the various agencies in the region. Clients are generally not interested in this level of engagement, thus any reporting back to the Department becomes one-sided and doesn't mean much.**

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

- **Same answer here as in Number 39; just replace the word clients, with providers, community organizations, etc.**

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

- **Our communities do not care to know about the ACC program. They just want to know that the medical and behavioral providers are doing their jobs in getting people in for care and referred to specialty care when needed. Thus, if enhanced community engagement would need to be created it would need to be "forced" through some type of award during the bidding/RFP process.**

42) How should the Department structure stakeholder engagement for the ACC as a whole?

- **Same answer her as in Number 39.**

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

- **No, it does not adequately serve the ACC population.**

a. If no, what are the gaps?

- **Here in the rural/frontier part of the State access to specialty care is a huge issue. Our population is an aging population and will not or cannot travel to Pueblo or Colorado Springs or Denver for care. We need specialty providers that spend several days a month in our area on a routine basis. Some of this is done through the local hospital, but it doesn't meet the demand.**

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

- **The gaps are not really specific to a certain population. I point out the elderly just because that is who we deal with a lot. However, if you talk to the school administrators they would probably give examples of gaps for their student population. It is a 0 to 99 age issue and not specific to any one population.**

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

- **Hospitals need to integrate and coordinate care. Most of the hospitals we work with do not do this at all or do it very poorly. In order for hospitals to play a role in the next ACC Program, they would need to be required to be active with CORHIO, for example. We are active with CORHIO but it doesn't do us any good because the hospitals do not utilize it. The hospitals would also need to be okay with referring clients to a different level of care which they might not want to do because they would lose money. Hospitals in the rural/frontier regions tend to isolate themselves and do not move out of their comfort zones. They could take a lesson from programs like Centura's Health Neighborhoods that collaborate and coordinate with providers in the community.**

b. What role should pharmacies play in the next iteration of the ACC Program?

- **I cannot think of a role for pharmacies.**

c. What role should specialists play in the next iteration of the ACC Program?

- **As I said earlier, specialty care needs to be more accessible in our rural/frontier region. Telemedicine has been a welcome addition to our programing. I think that incentives for agencies to build upon their telemedicine programs (or develop one if not developed) should be in the next iteration along with incentives for specialty providers to provide care in the rural/frontier region.**

d. What role should home health play in the next iteration of the ACC Program?

- **Home health should be involved in the care planning for those Members that need this service. They should be working closely with the nursing homes and hospitals.**

e. What role should hospice care play in the next iteration of the ACC Program?

- **Just like home health it should be available for those Members that need it.**

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

- **I cannot think of a role for these two entities.**

g. What role should counties play in the next iteration of the ACC Program?

- **The counties in the southeast region are very parochial in nature and rarely cooperate with other. I think that this would be opening up Pandora's Box and cause a lot of problems for our agency that provides services in 6 large (geographically) counties. It is hard enough now to work with 6 different sets of commissioners with 6 different ideas on what they want in the way of healthcare for their county. If you bring the counties in it would really muddy the waters. Thus, they should not have a role.**

h. What role should local public health agencies play in the next iteration of the ACC Program?

- **The role is one of a referral source for the network of ACC providers.**

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

- **We already have enough organizations at the table. If you bring in more that will have their own agendas for healthcare it will really cause a lot of issues. I can see our main supporters and network providers dropping out if this should happen.**

45) How can RCCOs help to support clients and families in making and keeping appointments?

- **The only thing that has worked for us is lots and lots and lots of outreach and follow-up calls to make sure that clients remember their appointments. This will always be an on-going problem and I don't know that involving the RCCOs will change much.**

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

- **No, it should not be required. I think that HCPF should stay away from a lot of requirements and instead allow the bidders to offer up their own solutions for a lot of the questions that are being asked in this RFI. We have Health Navigators that we would build into our RFP response.**

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

- **As I said above, HCPF should stay out of this level of detail and instead have the bidders offer their own solutions in their RFP.**

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

- **Just like behavioral health is healthcare, oral health is also healthcare. So the RCCO's should be helping oral health to integrate and coordinate services.**

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

- **Our clients receiving services in the way that best suits them through our local customs and traditions.**

b. What RCCO requirements would ensure cultural competency?

- **This questions is like asking, "What RCCO requirements would ensure that teenage girls in southeastern Colorado do not get pregnant!" Cultural competency cannot be regulated or required; it can only be shown to be understood by an agency through their words and more importantly through their actions with clients and customers. It would be better for HCPF to ask a bidder to demonstrate how cultural competency is active in their organization and community.**

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

- **It depends on where the organization is located (city, urban, rural, frontier) and what values the organization teaches its staff when doing cultural competency training. Plus, the clients/families themselves will dictate the types of skills the staff need.**

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

- **Again, making requirements is not the way to go. Ask the bidders to offer up their own solutions.**

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

- **No, this should not be part of the next RFP. If a specific RCCO feels that this a needed in their region than they can take care of it.**

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

- **For years, we have educated our clients through diversion programs and protocols how to avoid going to the emergency room and what to do instead. The ACC should do the same – develop diversion programs that redirect clients to community based care rather than inpatient.**

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☒	☐	☒
Network provider education	☐	☒	☐	☒
Assistance with practice redesign	☐	☒	☐	☒
Assistance with efficiency-enhancing activities	☐	☒	☐	☒
Provide web-based resources and directories	☐	☒	☐	☒
Provide practice-specific data reports	☐	☒	☐	☒
Provide clinical care guidelines and best practices.	☐	☒	☐	☒
Provide clinical screening tools	☐	☒	☐	☒
Provide health and functioning questionnaires	☐	☒	☐	☒
Provide chronic care templates	☐	☒	☐	☒
Provide registries	☐	☒	☐	☒
Offer client reminders	☐	☒	☐	☒
Offer client self-management tools	☐	☒	☐	☒
Offer educational materials about specific conditions	☐	☒	☐	☒
Supply behavioral health surveys	☐	☒	☐	☒
Supply other self-screening tools	☐	☒	☐	☒
Administer behavioral health surveys	☐	☒	☐	☒
Administer other self-screening tools	☐	☒	☐	☒
Prepare client action plans	☐	☒	☐	☒
Provide training on providing culturally-competent care	☐	☒	☐	☒
Provide training to supporting staff	☐	☒	☐	☒
Provide training on motivational interviewing	☐	☒	☐	☒
Provide tools and software for phone call and appointment tracking	☐	☒	☐	☒
Provide tools and resources for tracking labs, referrals, etc.	☐	☒	☐	☒
Provide referral and transitions of care checklists	☐	☒	☐	☒
Provide visit agendas or templates	☐	☒	☐	☒
Provide standing pharmacy order templates	☐	☒	☐	☒
Provide comprehensive directory of community resources	☐	☒	☐	☒
Provide directory of other resources	☐	☒	☐	☒
Provide materials regarding Nurse Advice Line	☐	☒	☐	☒
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☒	☐	☒
Others	**I am not at all in favor of this "one size fits all" type of approach. This should be left up to each RCCO/bidder to determine what fits for their region and what does not fit.**			

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

- **N/A**

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

- **As I have responded multiple times now, requirements are not the way to go. The bidders should offer up solutions, propose methods, vet ideas, etc. to address this and other areas of the RFI that speak to "requirements".**

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

- **The RFP bidder should include this in their response based on their particular PCMPs and locations. Most PCMPs want to be involved at this level only if their rate is higher than those that are not designated medical homes for the client.**

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

- **Again, "require" is a no. If the PCMP wants to use a disease registry than they should be able to do so.**

58) Please share any other advice or suggestions about provider support in the ACC.

- **I don't know how many times I said no in this section that seemed to be totally focused on having lots of requirements in the next phase of the ACC program. Requirements are the easy way out for a bidder because all they have to do is meet them. It is much harder for a bidder to come up with their own solutions backed up by data, experience, and a successful and satisfied client population.**

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- **Earlier in this document I pointed out that a risk contract is best. So a risk contract with a PMPM and goals for meeting the Triple Aim that are supported by financial incentives would be a good payment structure. I think that this is the best way to keep costs low and improve the health of a population.**

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

- **As a behavioral health organization, we are not PCMPs. However, we have worked under a Global Budget successfully for the past 18 years. I think that a Global Budget would work well for physical healthcare providers as well.**

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

- **No, providers cannot be successful in their current environment because it is a fee-for-service environment which is the biggest barrier to development of a system where payments are tied to value. Since providers are paid for volume rather than value, there is no incentive for them to change to a system based on value. Until the providers have to deal with a risk contract that has value as a main area of reward rather than volume, there is no reason for them to change. So the payment structure in the next RCCO RFP needs to be set up as a risk contract with value as the focus rather than volume and fee-for-service arrangements done away with forever more.**

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

- **We are currently an LSLPN, licensed by the DOI, so any additional licensure requiring reserves that may be needed would not stop us from bidding.**

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

- **The RCCOs should be totally in charge of distribution of payments to providers within their RCCO system.**

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- **Since the payment system that the behavioral health agencies have worked under for so many years has bent the cost curve and been so successful, I would stick with it – so a Global Budget with PMPM payments built through a rate setting process that takes into account the various factors at play. Also, quality needs to be part of the equation and rewarded.**

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	
SF-12 Health Survey	☒	☐	
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☒	☐	
Focus groups	☒	☐	
Other	Please type your response here. **Whatever is done needs to be started at the very beginning of the RCCO contract and not introduced in the middle of the contract. That has happened and it causes problems with the efficacy of the data.**		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

- **Since whatever the RCCO does has to fit into the Department's system, I don't think that population health can be measured any other way until the Department changes this function. The Department should have to pay for it and then the measurement needs to be the responsibility of the RCCO.**

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

- **In this day of technology it should be done by a website which makes it easy access for all.**

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☒
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

- **Yes, they should be paid on the same KPIs, however I do think that some of the local nuances need to be taken into account; rural/frontier is very different than downtown Denver.**

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

- **Improvement**

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

- **I don't understand why the RCCOs would have to wait on the State. The RCCOs should be able to monitor their own progress and report it to the state when the State is ready to handle the information. The State would have to make sure that each RCCOs measurement and monitoring process is valid, but other than that the RCCOs could go ahead and get started.**

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offeror's and other similar organizations: please describe the fixed costs of operating a RCCO.

- **What HCPF puts in the RCCO RFP will largely determine what the fixed costs of operating the RCCO will be. Of course, each RCCO will need staff to provide the necessary services so that is always the number one fixed cost. After that it really does depend on the requirements in the RFP. The resulting RCCO contract, rules and regulations all figure into a RCCOs fixed costs.**

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

- **As a community provider we are currently measured on 28 different measurements to assess the quality of our care. We are not reimbursed for any of these measures. I do believe that the RCCOs should be reimbursed for these measures as this is a "lost cost" for us in the way of the staff and technology needed to deal with the data and reporting requirements.**

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☒
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☐	☒
Smartphone app	☐	☒
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☒
Digital care management tool	☐	☒
Care transitions alerts	☒	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☐	☒
Practice assessment tools	☒	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☒	☐
Shared decision-making tools	☐	☐
Telemedicine software	☒	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☒	☐
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☒	☐	☐
Health risk assessment software	☐	☐	☒	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☒	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☒	☐	☐	☐
Patient education wellness tools	☐	☐	☒	☐	☐
Provider/case manager directory	☐	☐	☐	☒	☐
Shared decision-making tools	☐	☐	☒	☐	☐
Telemedicine	☐	☐	☐	☐	☒
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

- **The biggest barrier is staff not wanting to use it and second is the cost which is not reimbursable.**

81) How can Health Information Technology support Behavioral Health Integration?

- **HIT has a huge impact on behavioral health integration. For years we were not able to get a psychiatrist to move to La Junta to provide psychiatric services. Then when we decided to invest in telepsychiatry we had multiple psychiatrists willing to work for us from their place of business. We were concerned that our clients, especially the elderly, would not like meeting with a psychiatrist via an electronic system and our concerns were quickly put to rest as we got positive feedback from all populations, especially the elderly, on being able to talk to the psychiatrist via our large monitors that have no delay in the picture or speech. So HIT is a huge support for populations that live in the rural/frontier regions.**

- **Now we are ready to move more into telemedicine with our primary care providers, but there is a barrier. That barrier is the integration of our physical health and behavioral health information. We have searched for an EMR that combines the two into one well-designed electronic chart, but it doesn't exist. We have heavily invested in travel, hotels, and staff time by sending our IT and clinical staff to different locations to look at the different products on the market. What we have found is that an EMR is either really good on the physical side and has lots of weaknesses on the behavioral side or vice versa. Until these two disciplines can be merged into one EMR, true integration will not happen and will keep the physical health providers from wanting to work with or integrate with behavioral health.**

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

- **Yes, there should be a shared resource for data and analytics. I think that the basic criteria should first start with each RCCO bidder in their RFP response describing how they are going to gather, report on, and transmit the data to HCPF. I do not think that HCPF should be totally responsible for this platform. If the RCCOs are put in charge of getting the data to HCPF I believe that HCPF would see better results.**

- **What should be transmitted to HCPF by all RCCOs is the cost of care and any health outcome measures that impact that cost of care.**

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

- **Our SyCare partnership developed a shared care management tool that provides "real time" data to monitor individuals who have accessed emergency room/inpatient care in our region and this is now used by our RCCO. Every now and then there is a delay in transmitting the information, but it is still delivered within a 60 minute period of time. It would be nice to take the next step into tracking pharmaceuticals and health appointments at any health agency in our region so our care managers can track the individuals health care access needs.**

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

- **Yes, and I think that this should be the responsibility of each RCCO. Criteria should be developed to look at duplication of services, lack of access, appropriate treatment protocols, satisfaction of services, and outcomes for the various populations. Since population health management is a big undertaking for a provider, they would need some type of incentive to participate in order for efficiencies to be met. As I have said throughout this response, a risk based contract works best in these situations.**

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

- **The needs of the client should drive how the provider directory is set up so clients can search for providers based on their particular needs.**

86) How can the RCCOs support providers' access to actionable and timely clinical data?

- **Getting all providers to utilize CORHIO would be the best way to accomplish this.**

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

- **An integrated physical health and behavioral healthcare electronic health record that gives all providers immediate access to real time data and allows for the tracking of the patients progress, medications, appointments, and overall access to care would be most beneficial.**

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

- **The RCCOs should be totally responsible for the HIT infrastructure in order to have a broad network of providers. In the rural/frontier areas many providers cannot afford the cost of an electronic health record and still do paper charts. Until this is dealt with at the RCCO level, our region will not be able to provide the type of data and information asked about in some of the previous questions. The RCCOs should provide ongoing support for all providers.**

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

- **If HCPF is wanting an effective and efficient RCCO system, then CORHIO and QHN need to be at the table at all times.**

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

A new report from the Commonwealth Fund, "State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment," identifies key elements of an integrated health system and examines state strategies to achieve integration. For example, the authors identify the following strategies for states to consider:

- ***Consolidating agencies.***
- ***Placing state managed care contracting decisions for both physical and behavioral health under the same authority.***
- ***Providing financial incentives for providers and managed care organizations to integrate care.***
- ***Increasing data exchange across providers and departments.***
- http://www.commonwealthfund.org/publications/fund-reports/2014/aug/state-strategies-behavioral-health

I believe that the health information technology program for the ACC program should be the catalyst for integrating care, increasing data exchange, and providing improved overall access and quality service for all individuals needing healthcare within a RCCO region.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 017

Accepted by: KJDW

Notes: Standardized formatting; de-identified at client's request. Redacted by order of HCPF Legal.

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

[redacted]

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[1] Many terms and definitions can be found in the Appendix at the end of this document.

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[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

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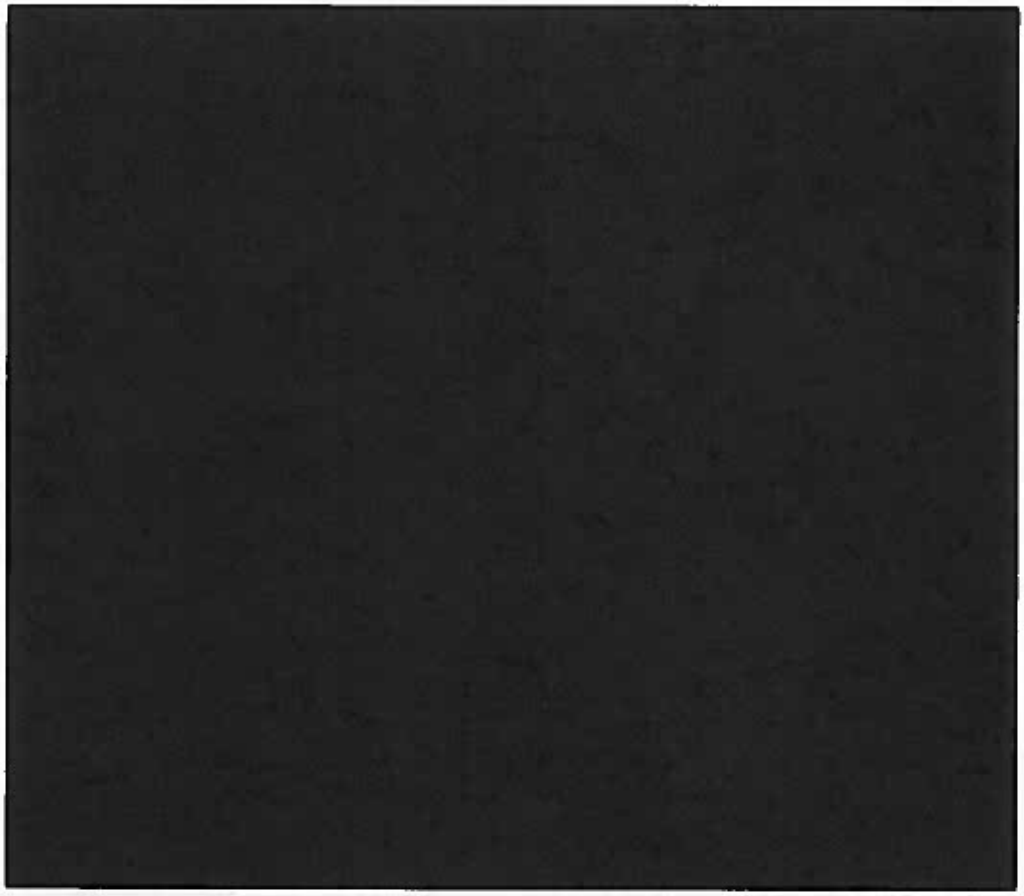

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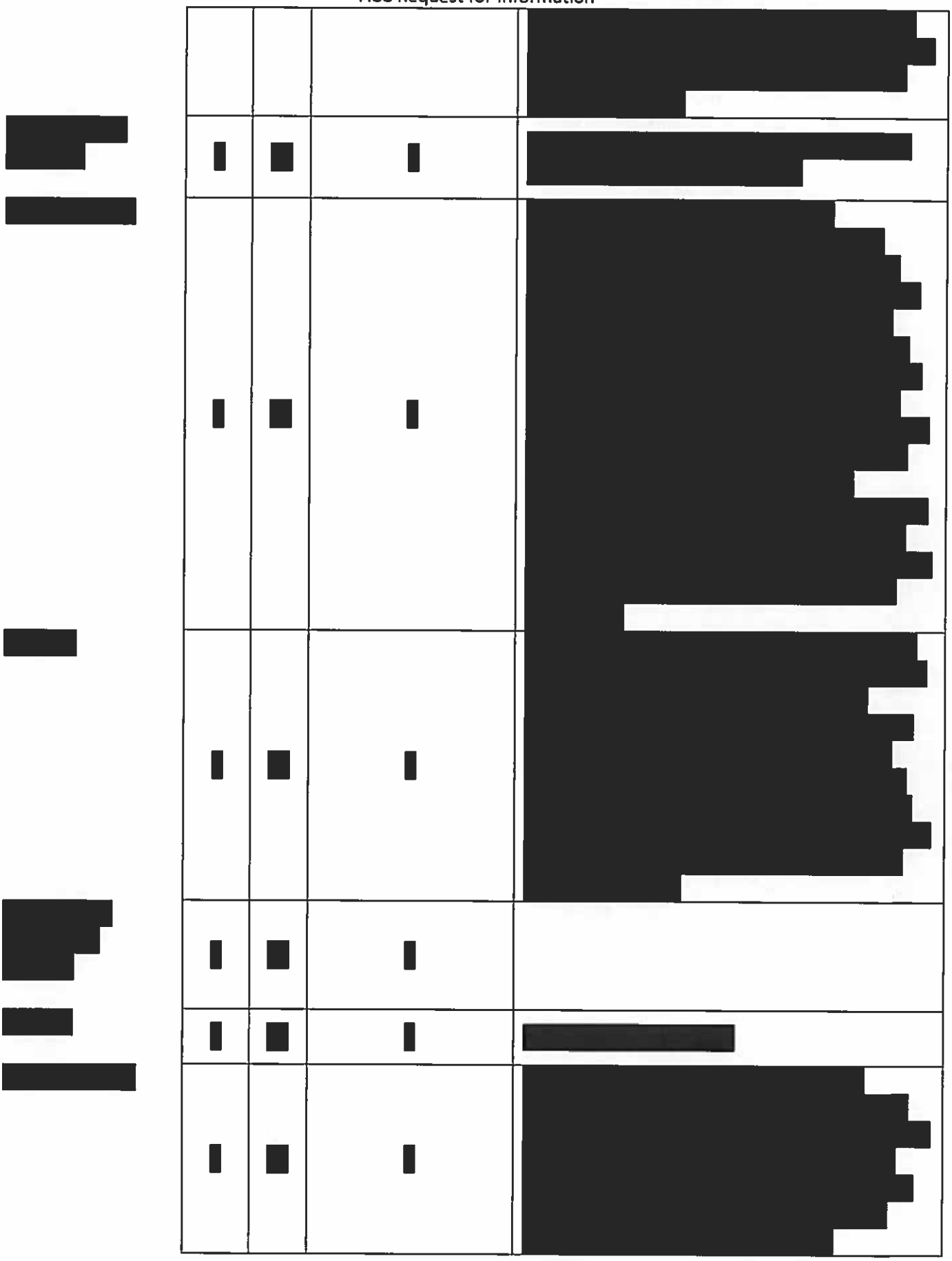

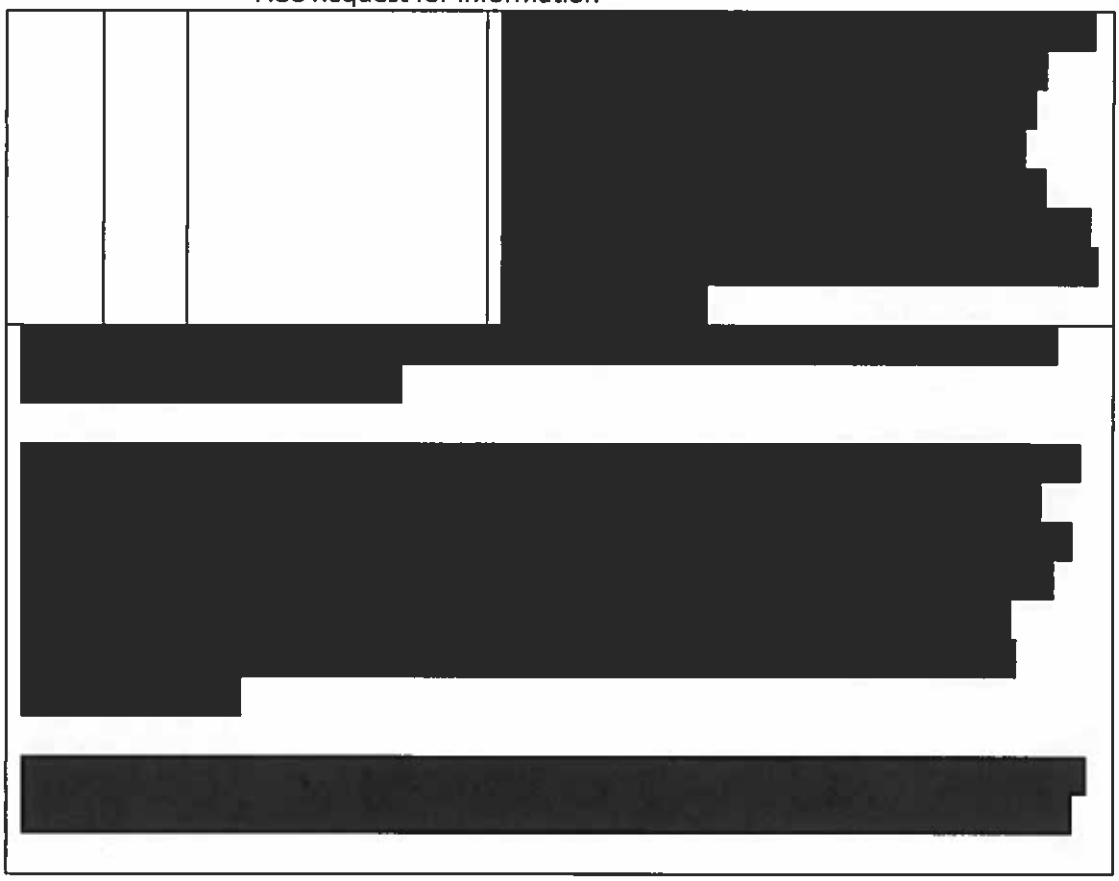

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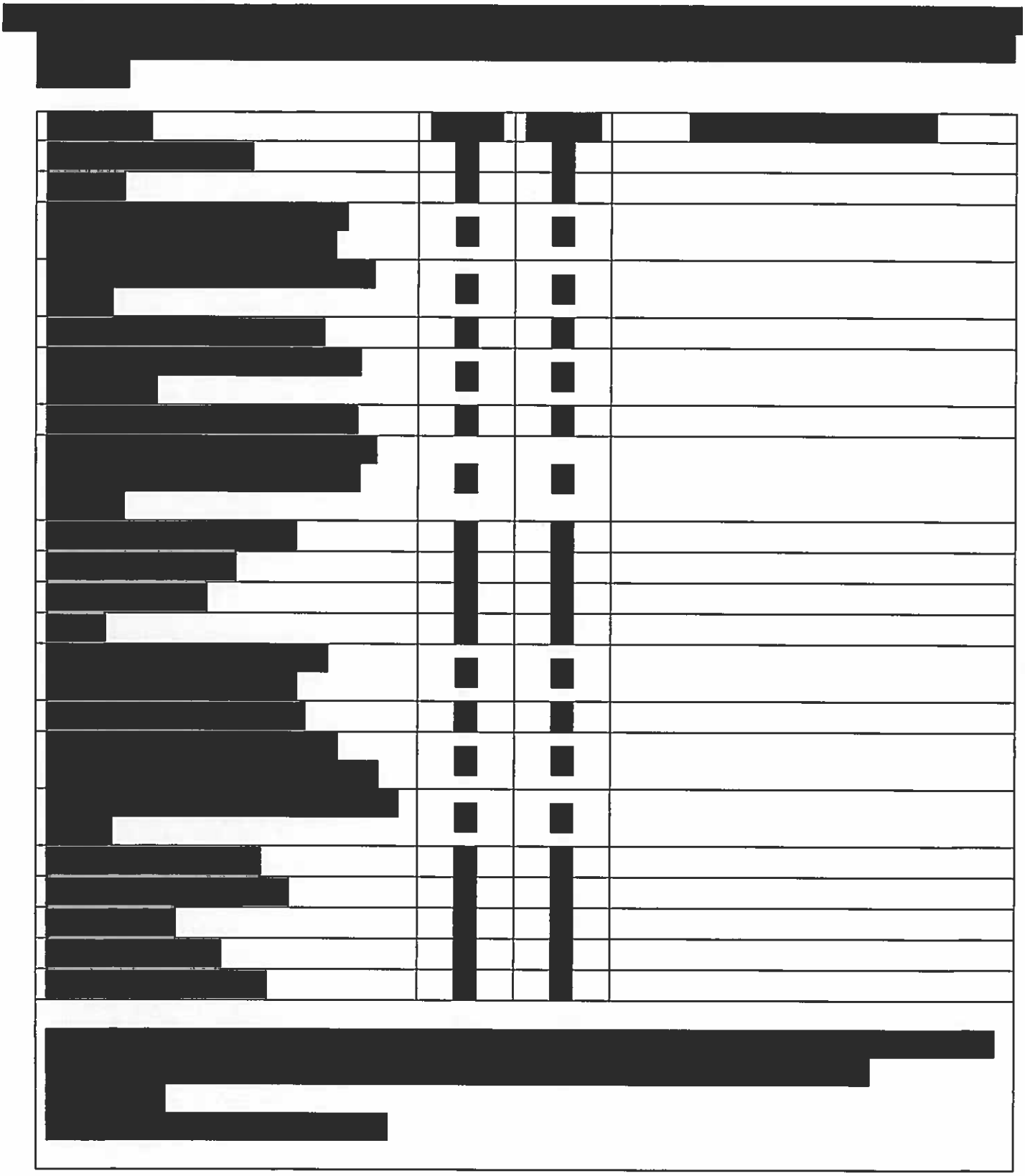

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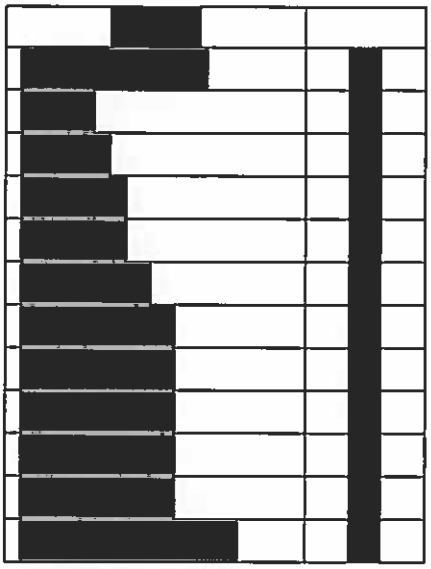

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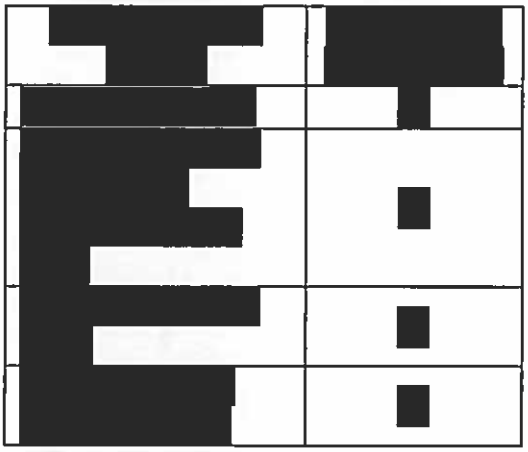

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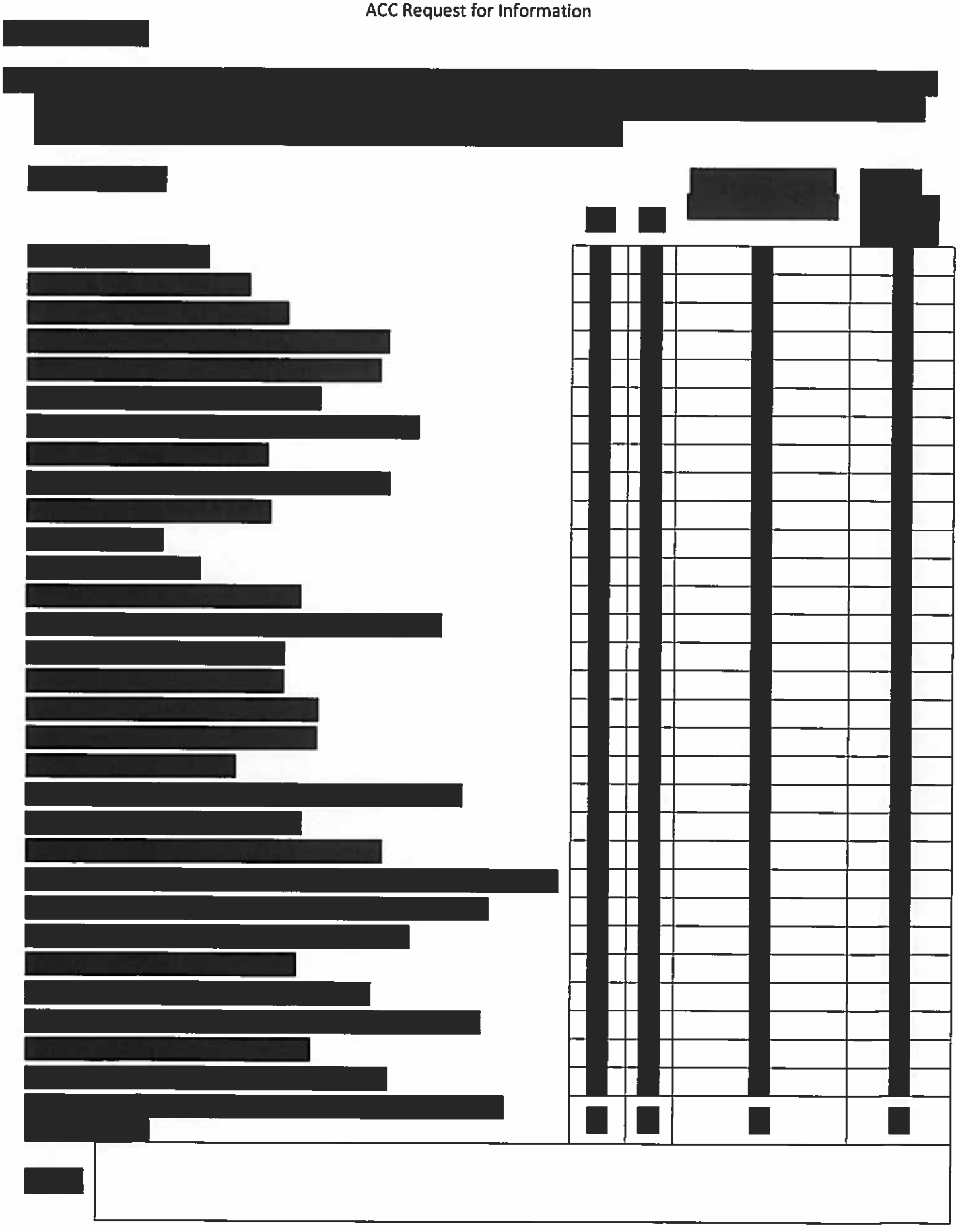

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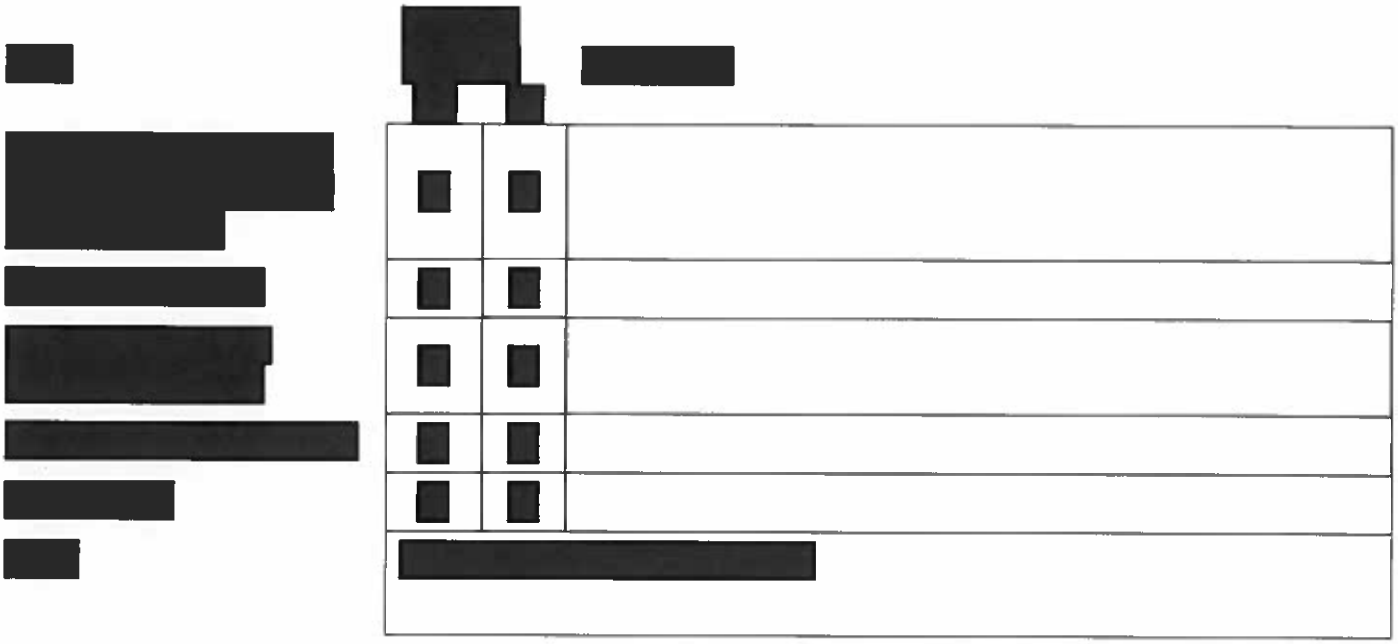

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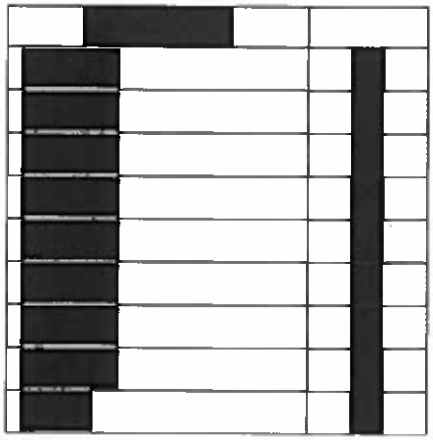

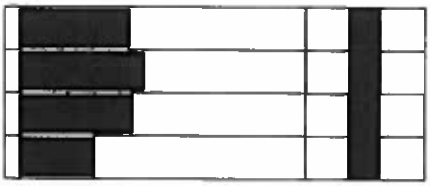

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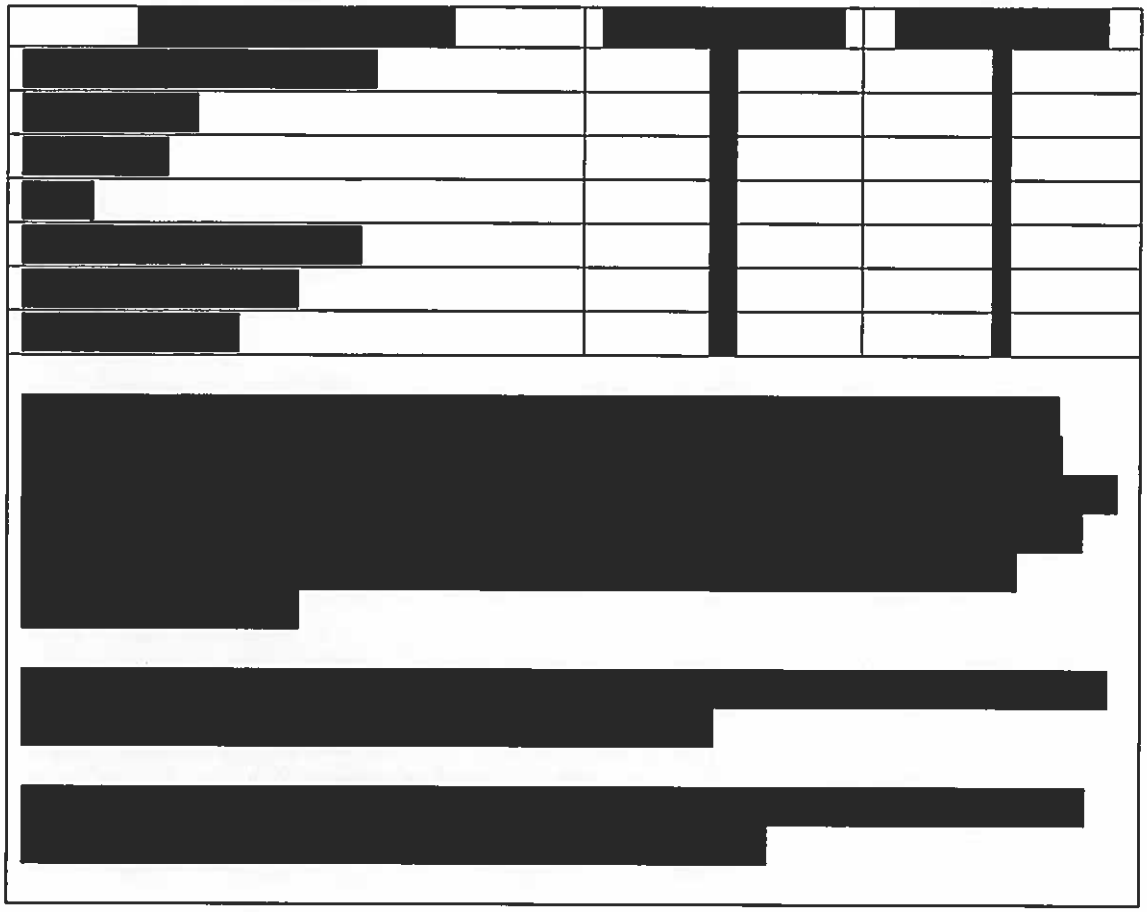

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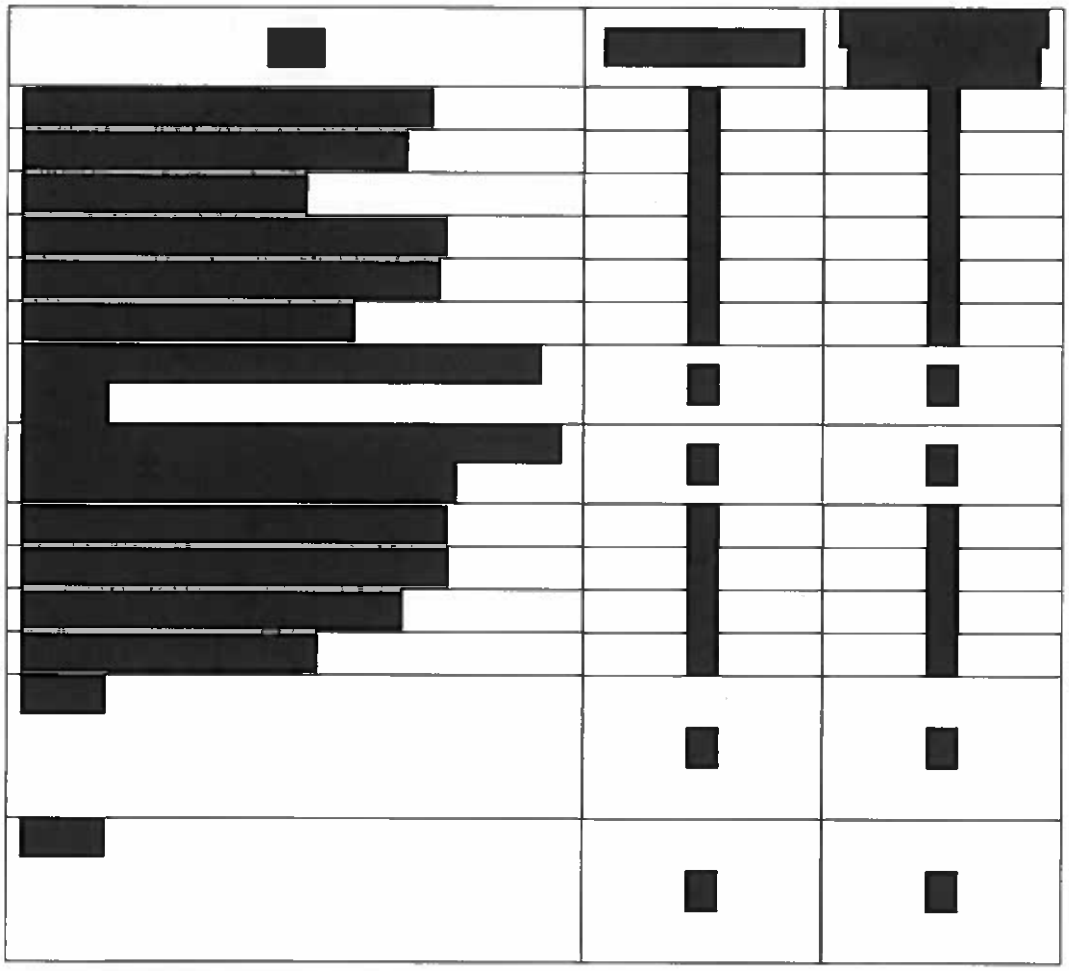

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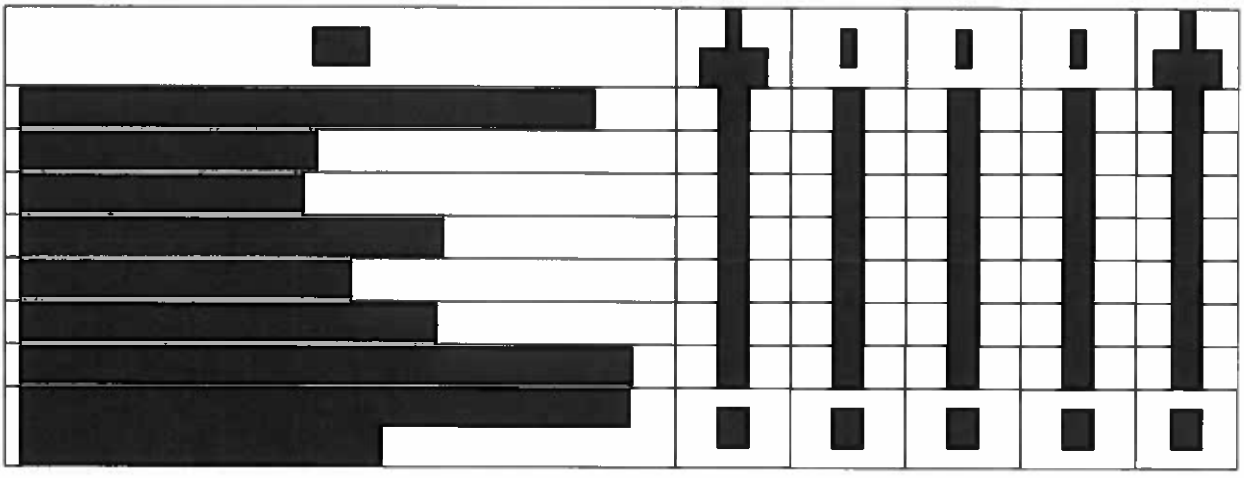

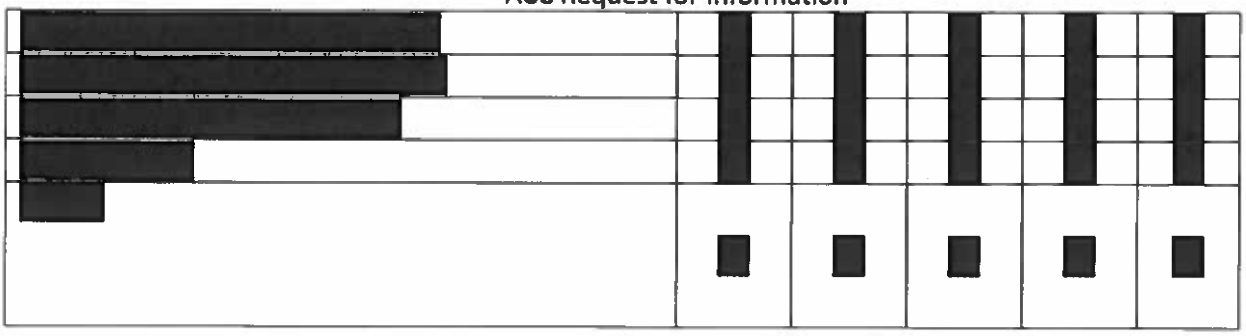

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Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 018

Accepted by: KJDW

Notes: Standardized formatting, removed blank number from sequence

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Bern Heath, Ph.D.
Location: Durango, La Plata County, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Axis Health System
Location: Dolores, Montezuma, La Plata, San Juan and Archuleta Counties and municipalities
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☒ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Community Health Center (FQHC)
  ii. Area of practice: Primary Care
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☒ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☒ 1-2 years
☐ 2-3 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
We are in RCCO Region 1 and are funded for attributed patients at our Cortez and La Plata integrated primary care clinics and have a contract for 3 Positions under the Community Care Coordination Agreement.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
We are both a community health center (FQHC) and a community mental health center. As a community health center we are part of the prospective payment structure. As a community mental health system we are part of Colorado Health Partnership BHO and we bill FFS for non-covered services.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- **Though Region 1 is unrealistically large, the structure allows for use of resources to best serve unique community needs.**
- **The data we are getting is helpful from a claims basis.**

2) What is not working well in the ACC Program?

- **The initial focus on chronic care management has not evolved into more integrated care approaches.**
- **Most importantly (and with regard to Section 1.3.4) substantive payment reforms essential to truly integrated care have not occurred. Traditional fee-for-service (FFS) billing does not support higher levels of integrated care. FFS structures stumble over same day billing restrictions and do not reimburse for consultations without the patient present, electronic contacts or a large volume of care management all of which we have found to be essential for improved health outcomes in an integrated healthcare system. FFS structures inadvertently provide incentives for ineffective, fragmented and churned visits rather than active management of care focused on health outcomes. FFS is also the most expensive payment structure both for providers and insurers as it requires excessive administrative resources for the billing and verification processes at the encounter level. We have to align coverage and payment reform to support integrated care. We believe this requires a global capitated structure.**

3) What is working best in the Behavioral Health Organization (BHO) system right now?

Colorado Health Partnerships is a mature managed care organization. We have not only been incredibly effective in reducing the per cap cost of care through reduced need for out of home care, we have a significant penetration rate and are picking up very challenging cases earlier.

In addition, we have some the leaders in the integration of care in our BHO and we have a strong collegial relationship between our organizations, allowing effective and best practices to be shared and adapted to different regional needs.

4) What is not working well in the BHO system?

The funding structure is more accurately represented as a Fee-For-Service (FFS) structure in Managed Care clothing. We are paid through a global cap structure (PMPM), but are required to account for individual service units and have our rates set on units using a FFS structure as a means to measure the value of the contract. This preserves the excessive cost of FFS structures (service unit verifications) for both the provider and insurer. It has the further significant failing of dis-incentivizing innovative integrated care designs that do not fit traditional FFS reimbursement models but effectively care for patients.

5) What is working well with RCCO and BHO collaboration right now?

Our BHO is working actively to prepare for a merging of RCCOs and BHOs. We hope to bring both extensive integrated care models and mature risk management to the RCCO table.

6) What is not working well with RCCO and BHO collaboration right now?

The collaboration is challenged by the geographic regions which do not match up well. With too much emphasis on population centers, the regions should be re-designed to take maximum advantage of the regional BHO service relationships which are well established, highly functional and effective for patients.

Region 1 is prepared for a global capitated structure, but the move has been slow to nonexistent. Until global cap is achieved, co-location rather than integration will be the limit of care. This hurts Axis Health System with 2 integrated clinics that will be hamstrung until global capitation is available.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

We need to move to more integrated models of care, which will move us from unit of service (volume) accountability to population based outcome accountability (value as CIVHC) puts it. If we are to move beyond co-location, a global cap payment structure will be needed. The RFP should provide points for existing progress toward more integrated models of care and population outcome data and incentivize continued progress in this direction

The only national system of behavioral health serving all populations is the Community Mental Health Center (CMHC) system. The only national system of primary care serving all populations is the Community Health Center (CHC) System (referred to as FQHCs). Any statewide effort to establish integrated healthcare must incorporate both systems. CMHCs and CHCs have been working increasingly closer together over the past two years and have found many local ways to partner through co-location and more recently in more integrated models. The RFP should incentivize this increasing collaboration by giving preference to applications that effectively bring CHCs and CMHCs together and should provide incentive funding for more permanent structures (such as joint ventures or jointly owned facilities).

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services**. Using the table below, please explain which issues are barriers, **and how they can be addressed:**

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	**See responses to #2 and #4 above. We have a FFS encounter based foundation for a capitation contract and need a global cap structure with a population based outcome payment structure. This would both significantly improve care (providing more flexibility for innovative integrated care models) it would also cost less by eliminating the misguided (measuring the wrong thing) FFS accountability structure that requires excessive administrative resources both for the provider and insurer.**
Community Behavioral Health Services Rule	☒	☒	
Covered diagnoses list	☒	☐	**Covered diagnoses are intended to limit the scope of responsibility and hence of cost to a program. If we truly wish to patient centered care, serve as medical or healthcare homes and improve outcomes through more integrated models of care, then we must provide incentives for whole-person, integrated healthcare including coordination between existing Community Health Centers and Community Mental Health Centers. The PMPM should be recalculated without the limit of covered diagnoses for integrated primary care.**
Different behavioral / physical health reimbursement	☒	☒	**This can be circumvented as VT did by pooling funds at the State level, or it can be managed locally (at some cost and effort) as we have done and presented to HCPF. The very sophisticated document that resulted is available if desired from either Axis Health System or Colorado Health Partnerships.**
Institutions for Mental Diseases exclusion	☒	☐	**As I understand it, the 191S(b)(3) waiver gives us some room.**
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	**CMHCs and CHCs are getting hammered by increasing administrative demands made far worse by their inconsistency in structure, reporting requirements and timing between State agencies. Few agencies today have a single grant contract. There are multiple payers, multiple deliverables and a lack of alignment in how**

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

			to value patient impact. Demands vary by State Department and within departments by program.
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☒	
Physical space constraints	☐	☒	
Privacy Laws (HIPAA, 42 CFR)	☐	☒	**FERPA (confidentiality provision in the educational setting for school based health or college based services) is also a factor. Substance Use's 42 CFR Part II is in revision and it would be much better (frankly for both providers and patients) for the three systems to merge into one, but there are ways to accommodate the separate structures if need be.**
Professional / cultural divisions	☐	☒	
RCCO or BHO contracts	☐	☒	
Staff capacity	☒	☐	**Whether CHCs or CMHCs, the rapid expansion of Medicaid has outpaced the labor pool. This is especially true of medical providers. This makes the need for midlevel medical practitioners even more acute – especially in rural areas. This will stabilize over time, but re-visiting reciprocity, the time it takes for independent practicing nurses to be licensed in Colorado, and the scope of practice for trained nurses important considerations. If these cannot be changed statewide, perhaps in designated rural areas with Medically Underserved Populations (MUPs) we could have a different standard.**
State/Federal rules or reporting requirements	☒	☐	**See response to OBH rules above.**
Technical resources / data sharing	☐	☐	
Training	☒	☐	**There are NO good academic healthcare programs providing training in integrated, whole-person, healthcare. This is an added burden to local providers as we have to train and re-train new employees.**
Others	**Please type** your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

The best resource for this is *A Standard Framework for Levels of Integrated Healthcore* published by the SAMHSA-HRSA Center for Integrated Health Solutions in April 2013. This can be simply and accurately assessed by a simple decision tree tool, the *Integrated Practice Assessment Tool* (IPAT) developed by a collaboration of Psychologists from Colorado Access, Value Options and Axis Health System. It can be found at www.IPATS.org.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

When we talk about our "healthcare system" we are not being accurate because it really isn't. It is for the most part not about health, but about illness. It is not about care; it is about services and service units. It is not about a system, but a set of fragmented resources. What we really have in this country and in Colorado is not a healthcare system, but a sick service set of resources. What we need is a health care system.

The Affordable Care Act is establishing a healthcare system by ensuring that all Americans have access to affordable care and providing structures to make services less fragmented. In so doing, the Affordable Care Act has committed to Berwick, Nolan and Whittington's concept of the Triple Aim....that healthcare reform, to be successful, must meet three goals: the improved experience of care, the improved health of the population and reduced per capita cost of healthcare. We have come to know that the integration of healthcare is essential to achieve all three components of the Triple Aim and hence, to the success of healthcare reform.

Everyone wants to do integrated care until they realize that they have to change how they practice". When they realize they have to change how they practice, they try to change the concept of integration to accommodate their current practice instead. It is critical that any RFP understand and require practice change if there is to be any meaningful progress toward integration.

The shift to accountability through population based outcomes is critical to achieve both the best care and greatest cost savings. In our field, we have a tendency to measure the wrong things. The number of inpatient bed days will give us a sense of our financial exposure in an "at risk" environment, but it does not inform care. By itself it will not tell us what we need to do differently to improve health.

At Axis, we have selected five measures we take at enrollment and then quarterly on every person we serve (i.e., it is a population measure). These measures are PHQ-9 (for depression), AUDIT (for substance use), HRQOL (self-report of unhealthy days), BMI, and Blood Pressure.

We selected these measures strategically.

- **The measures had to be population-based; applicable to all patients coming in to any location regardless of type of location and the purpose of their visit.**
- **We had to start with a manageable set of key measurements and not try to measure everything.**
- **The measurement had to fit into the workflow of each location and not require a particular staff discipline (e.g., nursing) to collect.**
- **The measures had to have proven validity for health outcome.**
- **The measures had to be age appropriate.**

Albert Einstein famously, and astutely noted: "We can't solve problems by using the same kind of thinking we used when we created them." Integration takes patience, commitment, thought and effort. It is complex, mostly not understood, underappreciated and difficult to implement. But it delivers the best care, saves healthcare dollars, and improves the patient experience of care.

Care Coordination

11) Care coordination is an important part of the ACC Program.

A cautionary note here...care coordination and navigation can actually obstruct increased integration by giving systems a mechanism to connect without requiring the primary providers do the work of, or take a different level of responsibility for, coordinating care.

a. What is the best definition of care coordination?

The deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services.

b. How should RCCOs prioritize who receives care coordination first?

We might want to look at this another way. A fundamental principle of care *integration* is that all care is coordinated within and between organizations. It is not a separate service but an essential component of the concept of care.

c. How should RCCOs identify clients and families who need care coordination?

All patients and families need and should receive coordinate care right up through level 6 integration.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

Tracking should be unnecessary as it is a presumed component of all care. What we should be measuring is outcomes, not services and service units (see response to funding questions above).

12) What services should be coordinated and are there services that should not be a part of care coordination?

All services should be coordinated within and between practices.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

This cannot be answered without the context of the patient.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

This is the problem. More fragmented, one off coordination hurts care and compromises outcomes. I would hope the re-bid would strategically consolidate such efforts and incentivize care coordination as a fundamental component of the integration of care, not a program in which a patient is involved.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

This is the wrong question...see above.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

See "a." above

d. What are the gaps in care coordination across the continuum of care?

The gaps occur because care coordination is seen as a program, not integrated into the model of care.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Please note...they may be, in the traditional sense, non-medical needs, but they are NOT non-healthcare needs. If we are to integrate care, these issues must be an active part of whole-person care.

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☒	**This should be part of the healthcare assessment and health care through the RCCO must address these issues to be effective.**
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	
Daycare / childcare	☐	☒	☐	
Economic stability & employment	☐	☒	☐	
Education	☐	☒	☐	
Environment	☐	☒	☐	
Food access / nutrition	☒	☐	☐	**This is an essential medical issue related particularly to healthy lifestyles and prevention of chronic illnesses (Type II diabetes, etc.)**
Health literacy	☒	☐	☐	**Important if we are to improve patient engagement and personal responsibility for patient's own health**
Housing	☐	☒	☐	
Language or translation services	☒	☐	☐	
Literacy	☐	☒	☐	

Transportation	☒	☐	☐	**Particularly as it relates to crisis services and inpatient transports in rural areas**
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Note: Care coordination is everyone's responsibility in terms of patient need (identification) and in terms of contributing expertise to the care. However, I have checked "yes" below only for those whom I see as directly transporting or making the initial contact.

Type:	**Coordinate care?** Yes	No	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☐	☒	
Certified Addiction Councilors	☐	☒	
Certified Nurse Midwives	☐	☒	
Community Health Workers	☒	☐	
Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☐	☒	
Licensed Marriage and Family Therapist	☐	☒	
Licensed Mental Health Counselors	☐	☒	
Licensed Professional Counselor	☐	☒	
Masters of Public Health	☐	☒	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☒	
Nurse Practitioners	☐	☒	
Patient Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☒	☐	

Psychiatrists	☐	☒	
Psychologists	☐	☒	
Registered Nurses	☐	☒	
Social Workers	☐	☒	
Wraparound facilitators	☒	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☐	Requires special sensitivity to new parent issues especially for first born.
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☐	☒	
Children involved in the foster care system	☒	☐	Requires special sensitivity (e.g., trauma informed care and attachment issues)
Children with a chronic illness	☒	☐	Depends on the illness and level of control. Type 1 Diabetes would require some special expertise, for example.
Children with a serious emotional disturbance	☐	☒	If adequate behavioral health back-up.
Children with medical complexity	☐	☒	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☒	
Transition-age adolescents	☐	☒	
Parents and families	☐	☒	
Pregnant women	☐	☒	
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☐	☒	
Adults with a chronic illness	☒	☐	Depends on the illness and level of control.
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	Depends on severity.
Clients involved in the criminal justice system	☐	☒	
Clients with a disability	☐	☒	
Clients in a nursing facility	☐	☒	
Elderly clients	☐	☒	
Frail elderly clients	☒	☐	
Clients in palliative care	☒	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

    a. What is the PMPM cost for providing care coordination services?

This would have to be actuarially calculated but should not be a separate component. We would be best served by a global cap funding structure which looked at overall cost of care, provided a PMPM that would equal that primary care cost and allow the providers to share in any savings. This is a sound strategy to start with, but presuming diminished returns from cost savings over time, would need to have a floor so as not to create a death spiral.

    b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

See response above. The PMPM for total care could vary, as it did in Minnesota, by range of eligible chronic conditions with complexity tiers with varied payment structures to adjust for different approaches to patient care: 0, 1-3, 4-6. 7+ might work.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

    a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

Accountability should not be service based, but population based. That is, we should not preserve the service volume mind set, but population based health outcomes by site.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

I think it would be essential for data reporting to and from the RCCOs to have some standard components (though additional data could be selected by RCCOs with their partners). I would also suggest a minimum group of population based health outcomes (e.g., change in depression, substance use, BMI, BP, CDC HRQOL). Measures like inpatient days are financial risk measures, not population health measures. Inpatient bed day measures do not specifically inform care. There is a difference in focus and application between risk measures and health measures.

Other than these items it would be essential for local latitude in care configuration to maximize both resources and effectiveness.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

We need not to prescribe processes and instead focus on outcomes. That is the accountability commitment that should be required.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is a reasonable suggestion, but likely will not be relevant to RCCO 1 covering a vast rural and frontier area.

27) Should the RCCO region maps change? Why or why not? If so, how?

The maps were driven by population, not by care systems in place. As a result RCCO 1 is way too large to make consistent practice practical or effective. In addition, the structures in Larimer County do not have existing or natural connections to the rest of the region. The regions should change, be restructured to accommodate existing, established and proven BHO and geographic boundaries (e.g., 5 counties of SW Colorado geographically together bounded by major mountain passes – though with only 92+K in population). That is, I would suggest Region 1 be split into 2 or 3 regions – each of which could be led by Rocky, but would have slightly different and more effective/responsive structures. The BHO regions have existed for some time and are effective care regions. Restructuring the map should ensure BHO boundaries are respected – Though CHP is too large to stay intact, it could easily be subdivided (still under CHP) into the three original MHASA regions without great disruption and the historic and effective ties among the three regions would serve the RCCOs well.

28) Should the BHO region maps change? Why or why not? If so, how?

See above.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

I would think that it would take 12 - 18 months. I do not have any sound estimate of the cost.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

First, Payment Reform (move to a true global cap)...Second, Payment Reform (move to a true global cap)...Third, Payment Reform (move to a true global cap).

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

See above

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

I have viewed the RCCOs as the region, but to the question, these regions could be subdivided without problematic competition.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

I am a Medicaid provider for both behavioral health and primary care.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

We already have too many conflicting masters. One State Department should have the responsibility for managing this and at the Department level could coordinate with CDPHE, but do not make the RCCOs and the partner organizations have to deal with multiple State Departments, multiple standards and multiple objectives while keeping all the funding entirely segregated.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

The RCCOs should have an enrollment/eligibility component to facilitate the State's Medicaid expansion and HBE, but should not be burdened with regular reporting requirements back to the HBE beyond the bare essentials.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

Honestly, we have a robust grievance and noticing procedures to ensure consumer feedback. If the State wishes, it could administer an independent consumer satisfactions questionnaire. Stakeholder processes are politically expedient but practice burdens that are rarely of material value where the rubber meets the road.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

Letters of support outlining roles should be sufficient. We need to keep our eyes on the ball of "population outcomes", not the outcomes *and* prescribed processes for achieving them. Either set the outcome requirements *or* require a prescribed process (which doesn't hold providers responsible for the outcome).

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

See above....and measure the right thing...outcomes. This will be the most effective way to drive the community involvement you want to see, but community involvement is not the object....achieving outcomes is the object.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

See the answer to 39 above.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

There needs to be a more formal place and role for CHCs as well as for RHCs. Rural and Frontier areas will have staffing challenges at all levels.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

The gaps are geographic, discipline and provider specific, not population specific.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

Hospitals have a strong role to play, but not the central role they have been used to. Primary care offers the opportunity to capture the long hanging fruit in cost reduction but need the hospital inpatient and lab resources as well as entrée to the specialists' structure. However, most hospitals are neither used to nor comfortable with a genuine healthcare partnership. One of the exceptions is Mercy in Durango which is a Centura Hospital. Partnering as part of a system to improve health outcomes rather than driving care is the best role for hospitals.

b. What role should pharmacies play in the next iteration of the ACC Program?

Engagement through primary care systems.

c. What role should specialists play in the next iteration of the ACC Program?

Specialists are moving increasingly into partnership with or under Hospitals. They are the hardest to work with as they are most resistant to the practice change and care coordination required of integrated care.

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

Public health agencies have great expertise in population based health and health indicators and in prevention, all of which are extremely valuable in designing care and modifying resources to meet unique

community needs. I would think that they should be actively engaged as ACC partners. We have done so and are much better for it.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

There is a danger of too many cooks in the stew and there is a risk that prescribing local relationships will be less effective than holding partners accountable for outcomes. Healthcare reform must be developed by healthcare professionals (administrators, payers and providers) in order to be meaningfully changed and administratively manageable. The concept of healthcare reform will not be successful if it is lost in a "grass roots" approach at this point. Broad input is important, but solution development needs to be focused so that changes are meaningful for those at risk (patients, providers and payers).

45) How can RCCOs help to support clients and families in making and keeping appointments?

I don't believe the RCCOs can help. This is an issue of great import to all behavioral health and primary care organizations and each, knowing its own population, are capable of developing the best regional strategies.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

Health Workers and Navigators are not always the best alternative and can have the unintended impact of relieving systems of the need (by transferring the effort to these positions) to actually maintain contact and coordinate care with other parts of the healthcare system. Hold regions accountable for outcomes, provide adequate funding to achieve those outcomes, but let the RCCOs determine the best strategies for achieving them.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

I would think that the RFP wording would be something along the lines of, "RCCOs will ensure that their networks are sufficient to the needs of the patient population to the degree practical and possible."

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

I would suggest an approach that sets rural/frontier and urban standards for expected emergency room utilization for what is deemed inappropriate emergency room utilization, provide the data on this utilization by hospital to the RCCOs, and expect/require that the RCCOs conform to (or come in lower than) the standard.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☒	☐	☐
Network provider education	☐	☒	☐	☐
Assistance with practice redesign	☐	☒	☐	☐
Assistance with efficiency-enhancing activities	☐	☒	☐	☐
Provide web-based resources and directories	☐	☒	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☒	☐	☐
Provide clinical screening tools	☐	☒	☐	☐
Provide health and functioning questionnaires	☐	☒	☐	☐
Provide chronic care templates	☐	☒	☐	☐
Provide registries	☐	☒	☐	☐
Offer client reminders	☐	☒	☐	☐
Offer client self-management tools	☐	☒	☐	☐
Offer educational materials about specific conditions	☐	☒	☐	☐
Supply behavioral health surveys	☐	☒	☐	☐
Supply other self-screening tools	☐	☒	☐	☐
Administer behavioral health surveys	☐	☒	☐	☐
Administer other self-screening tools	☐	☒	☐	☐
Prepare client action plans	☐	☒	☐	☐
Provide training on providing culturally-competent care	☐	☒	☐	☐
Provide training to supporting staff	☐	☒	☐	☐
Provide training on motivational interviewing	☐	☒	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☒	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☒	☐	☐
Provide referral and transitions of care checklists	☐	☒	☐	☐
Provide visit agendas or templates	☐	☒	☐	☐
Provide standing pharmacy order templates	☐	☒	☐	☐
Provide comprehensive directory of community resources	☐	☒	☐	☐
Provide directory of other resources	☐	☒	☐	☐
Provide materials regarding Nurse Advice Line	☐	☒	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☒	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

Referencing the SAMHSA-HRSA Center for Integrated Health Solutions publication, *A Standard Framework for Levels of Integrated Healthcare*, for purposes of consistency and comparison, the RCCOs could use the Integrated Practice Assessment Tool (IPAT) as a measure of level of facility integration. This would provide a mechanism to objectively determine progress in integration. The instrument combined with the publication provide useful information on what is required to move practices to higher levels of integration.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

The most effective *and* efficient way would be to ensure a global capitated payment with population based outcome accountability setting the stage for gain sharing as both recognition and incentive.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

No

58) Please share any other advice or suggestions about provider support in the ACC.

The most effective, and also the most efficient approach is to determine population based outcomes and key operational indicators – hold RCCOs responsible for achieving them – and resist the temptation to prescribe how they can be achieved. Said another way, the Department can prescribe how all care and services should be delivered (and hence the Department takes responsibility for the outcomes), or it can define the outcomes and key indicators and hold the RCCOs responsible for achieving them, but it cannot do both with any hope of success.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

Substantive payment reform is essential to truly integrated care. Traditional fee-for-service (FFS) billing does not support higher levels of integrated care. FFS structures stumble over same day billing restrictions and do not reimburse for consultations without the patient present, electronic contacts or a large volume of care management all of which we have found to be essential for improved health outcomes in an integrated healthcare system. FFS structures inadvertently provide incentives for ineffective, fragmented and churned visits rather than active management of care focused on health outcomes. FFS is also the most expensive payment structure both for providers and insurers as it requires excessive administrative resources for the billing and verification processes at the encounter level.

We have to align coverage and payment reform to support integrated care. We believe this requires a global capitated structure – payment on a PMPM basis without the overlay of unit cost to justify the expense. We would recommend that consideration be given to PMPM payments being tiered by number of chronic conditions (as was done in Minnesota) which roughly adjusts for complexity and cost.

We would also like to see this risk sharing model include gain sharing of the savings resulting from the integration of care...but a cautionary note is called for. If this were to be implemented, there would be significant savings the first year with reduced savings in subsequent years. Thus, gain sharing of cost reductions is a reasonable and sound approach for the first 1-3 years, but with diminishing savings as costs come down to stable levels then the reward system/incentive will need to be refocused to operational issues or consumer satisfaction (which loads on the Triple Aim of patient experience of care and hence engagement in their own treatment).

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

As both a primary care provider (1 FQHC, 2 School-Based Health Centers, and 1 private clinic) and as a community mental health center, we have been requesting such a structure for the past 3 years. We would and indeed could do it, and do it successfully, tomorrow if allowed. We have already developed the foundational structure needed to ensure transparency and appropriate use of the different Medicaid streams (prospective payment for the CHC, capitation under the BHO and access various Medicaid FFS payment structures). For our region and operation, all primary care and behavioral health services should be included in a primary care capitation.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

We are fully prepared to tie payments to value (outcomes). At Axis, we have selected five measures we take at enrollment and then quarterly on every person we serve (i.e., it is a population measure). These measures are PHQ-9 (for depression), AUDIT (for substance use), HRQOL (self-report of unhealthy days), BMI, and Blood Pressure. This results in the nine measures you see above in one of the first dashboard reports we published internally. The population screening is made possible by use of electronic assessments via PatientTools.

We selected these measures strategically.

- The measures had to be population-based; applicable to all patients coming in to any location regardless of type of location and the purpose of their visit.
- We had to start with a manageable set of key measurements and not try to measure everything.
- The measurement had to fit into the workflow of each location and not require a particular staff discipline (e.g., nursing) to collect.
- The measures had to have proven validity for health outcome.
- The measures had to be age appropriate.

The following is a dashboard look, generated by Axis internally, of the nine components resulting from the 5 population health measures:

Outcome Measurements by Location

Sample 1 (patients with positive screen, earliest screen May 2010), Sample 2 (latest screen April - Oct 2014)

Outcome Measure	Columbine Center	Pagosa Springs Center	Cortez Integrated Healthcare	La Plata Integrated Healthcare
Depression	●	●	●	●
Alcohol Use - Male	○	○	○	●
Alcohol Use - Female	●	insufficient data	●	●
Unhealthy Days - Mental Health	●	○	●	●
Unhealthy Days - Physical Health	●	○	●	●
Unhealthy Days - Disrupting Normal Activitites	●	○	●	●
Body Mass Index	○	○	○	○
Blood Pressure - Systolic	●	●	●	●
Blood Pressure - Diastolic	●	●	●	●

Key:
● statistically significant change, wrong direction
○ no statistically significant change
● statistically significant change, right direction
*statistically significant change not due to chance

The Columbine Center and Pagosa Springs Center are traditional behavioral health sites. Cortez Integrated Healthcare and La Plata Integrated Healthcare are integrated primary care sites at a Level 5 integration (using the IPAT). All sites are successful at improving patient depression and blood pressure. None of the sites are effectively addressing BMI. The integrated sites alone are consistently showing statistical improvement with alcohol use by women and with the CDC's self-report (HRQOL) of healthy days.

It will take a little time to determine if these measures are the best ones or whether others would be better, but we can clearly see that outcome measures can be successfully implemented in a population manner across all settings.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

As part of the Colorado Health Partnerships BHO, we are licensed by the DOI. Through the BHO (and in some instances independently) we are prepared to secure any license required and with adequate notice, set aside any required reserves.

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

The RCCO alone should be responsible for payment of the providers.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

See #62 above. Axis is also establishing a single exit question at our locations using a Likert Scale of 1-S; (S) my visit today was outstanding, (4) My visit today was good, (3) My visit today was just okay, (2) My visit today was not good, (1) my visit today was terrible. We are experimenting with this low patient intrusion, consumer satisfaction approach to see if it is sensitive enough to lead us to better care improvement strategies. These are examples of local creativity and local solutions that would not result from a prescriptive RFP.

66) **Measuring Client experience**. Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☒	
SF-12 Health Survey	☐	☒	
Other types of client interviews / surveys	☐	☒	
Patient Activation Measure	☐	☒	
Focus groups	☐	☒	
Other	Please type your response here. See response to #66		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

See answer to # 62 as a possibility. This should be the RCCO's responsibility with adequate funding by the State.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

Through a web site.

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐

11-20	☐
21-30	☐
31-40	☐
41-S0	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-S0%	☐
S1-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

The first and second year 41 – 50%, the third and fourth years 51 – 65%, the fifth year 66-75%.

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Yes

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Improvements to start, then national standards after initial cost savings have been achieved.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

I would hope the Department would not get stuck in the tar baby of claims and encounters which perpetuates much of the negative side effect of care delivery in a FF5 structure. The RCCOs have the horse power to develop and implement monitoring systems adequate to 5tate needs.

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

See #s 62 and 66 above. We also have BHO measures, OBH measures (different for substance use MSOs and mental health) and Community Health Center (FQHC) measures. These are separate, disconnected and uncoordinated. It would be of tremendous help if the RCCO could be the organizing entity for a single accountability system. In some instances these measures are compliance requirements, others are used to access full contract payment (though they claim to be incentives).

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☒
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☐	☒
Smartphone app	☐	☒
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☒
Digital care management tool	☒	☒
Care transitions alerts	☒	☒
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☐	☒
Practice assessment tools	☒	☒
Practice management tools (scheduling, billing)	☒	☒

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 019

Accepted by: KJDW

Notes: Standard cover sheet added; formatting standardized

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Margaret Sobocinski

Location: Carin' Clinic

5150 Allison Street

Arvada, CO 80002

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Carin' Clinic

Location: 5150 Allison Street

Arvada, CO 80002

☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Pediatrics
  ii. Area of practice: Primary Care
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Our RCCO (Colo Community Health Alliance) has helped us with QI projects and taught me how to use Treo to help track patients.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

We are a primary care clinic that serves low-income children, including those with Medicaid.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes

☐ Will not seek to participate
☐ N/A

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

Please feel welcome to describe why or why not using the space below.

If you answered "yes" above, how long?

☐ Less than one year
☒ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.
- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.
- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.
- The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. This is a great opportunity to do what is needed for the majority of Medicaid recipients. The following principles should be incorporated into the core objectives of the ACC:
    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children. By focusing on preventive care, early screening and early

intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.

- So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
- Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
- There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing SDAC data is just one way to understand the activities within a medical home. SDAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Core Coordinatian

Question 12) Whot needs far children/fomilies should be coordinated in medical homes ond are there services thot shauld not be a port of care coordinotion by the pediatric and fomily medical home

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be coordinated in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill? The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes.

In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives

that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

Payment Structure and Quality Monitoring

S9) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

- Since children are the majority and give the best chance of truly improving health and wellness, KPIs need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully. Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursed adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home.

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and provider from medical homes to develop a vetting process that will enable HCPF and RCCOs to trust medical home self-reported real-time data.

- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd. Appropriate child health measures could be selected from the following measures :
    - Well child visits appropriate for age
    - Developmental screening by three years of age
    - Teen depression screening
    - Complete immunization status by age two
    - Post-partum depression screening rate for mothers of newborns by age 4 months
    - Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
    - Patient (or family) satisfaction ratings
    - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 020

Accepted by: KJDW

Notes: Standard cover sheet added; formatting standardized

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Donald Moore
Location: Pueblo, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Pueblo Community Health Center
Location: Pueblo, Colorado
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Family Practice
  ii. Area of practice: FQHC
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☒ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Yes, PCHC helped form the Region 4 (ICHP) RCCO and is one of its nine owners. PCHC is also a PCMP. PCHC is extensively involved in the significant aspects of ICHP's operation and performance, i.e., care coordination, KPIs, data, governance, community outreach, etc. PCHC has also represented its RCCO on the PIAC.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

PCHC is an FQHC provider and serves 45% of the Medicaid population in Pueblo, County, including over half of all Medicaid newborn deliveries.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

1. As a major provider of services to the population, PCHC has a responsibility to contribute to ACC implementation success to assure ongoing access to quality health care. 2. The ACC is the single, largest opportunity for my organization to participate in health

care delivery and payment reforms and align our orientation to the Triple Aim.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

Triple Aim philosophy underpinning the program design; KPI and data focus/sharing; development of stronger, local provider collaboration and relationships; use of a QI/PI and population health/cost management model rather than an insurance model.

2) What is not working well in the ACC Program?

Attribution needs to be more robust based on experience gained to date; too many "initiatives"; lack of incentives for key players in the health care system to be involved (i.e., hospitals, specialists, public health, CCBs);

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

First and foremost, the provider/clinic should be able to assume responsibility and be accountable for the majority of a patient's care. Other characteristics should include 1) the clinic provides physical and behavioral health in a common setting ("one stop shop"); 2) clinicians use a common patient health record/HIE that facilitates a shared care plan; the clinic is accountable for access to care and population health/cost management measures reflective of integrated care, and 3) provides or arranges for appropriate supportive and enabling services that recognize the impact of socio-economic factors on health.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

A general comment – the ACC program should 1) rely on the literature to describe the elements and standards in care coordination that describe best practices, and, 2) determine the outcomes it wants from care coordination activity. With this information, HCPF could hold each RCCO accountable for outcomes while the RCCO should have the flexibility and latitude to determine the care coordination strategies that work best in its region and local communities. The resource, agency and provider mix in each "sub-region" of the RCCO region is varies and a prescriptive definition is going to cause frustration and consume RCCO resources to meet criteria that may or not be important to impacting cost and population health goals. In summary, it would be most helpful to shift ACC program design regarding care coordination from a process to an outcomes focus.

11) Care coordination is an important part of the ACC Program.

   a. What is the best definition of care coordination?

   b. How should RCCOs prioritize who receives care coordination first?

   c. How should RCCOs identify clients and families who need care coordination?

   d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

   a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	
Health literacy	☐	☐	☐	
Housing	☐	☐	☐	

Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	
Transportation	☐	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination**. Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	

Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	

Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐

4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Letters of support from key stakeholders, community leaders and actors in the continuum of care; evidence of provider satisfaction and support across a broad mix of providers; ability to share data; embraces a Triple Aim philosophy.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

It depends. The department has expressed a desire for administrative simplicity which may be in conflict with increasing the number of regions. However, natural patient utilization patterns and established provider communication channels and systems of care may suggest smaller regions than may exist now. HCPF shouldn't use administrative simplicity as its primary criteria for definition regions if it desires to change the regions. Rather, a premium should be placed on what geographic boundaries encompass a) patient use patterns, b) groups of providers who have a shared commitment to the Triple Aim for a common population, and, c) sufficient numbers of patients to achieve economies of scale.

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

1) Balancing patient choice with expectations and rules to utilize care appropriately.

2) There is tension between increasing provider participation and concentrating patient attribution in practices that are committed to PCMH and the Triple Aim.

3) How much and what kind of risk does HCPF want to pass down to RCCOs, and their providers, and what rules, laws, etc. are needed to facilitate this direction? Does HCPF want RCCOs to be insurance companies or will it hold the risk if a RCCO can implement payment reforms?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

Client incentives are needed to motivate patients to use less costly and more effective services.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

This concept seems to run counter to the Dept's desire for administrative simplicity. If this direction is selected however there shouldn't be impediments to a provider being in more than one RCCO network.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

Providing customer service: treating patients according to their individual needs and having empathy and compassion for their background and station in life. In particular, it means being sensitive to socio-economic factors that impact health.

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

The KPI data in the first RCCO contract period suggests that higher ER use doesn't result in higher Total Costs of Care. It is understandable to maintain a focus on lowering ER use so as to increase a patient's interaction with preventive and primacy care with a PCMP, but it may not be a significant factor in cost management.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐

Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

Yes, depending on what is included in the capitation payment (i.e., factors within a primary care provider's influence). It would be helpful to have payment adjustments based on social determinants of health in addition traditional risk adjusting factors.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 021

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Rose Pediatrics

Location: 4545 E 9th Ave, Ste 260

Denver, CO 80220

9137 Ridgeline Blvd, Ste 130

Highlands Ranch, CO 80129

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization:

Location:

☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Pediatrics
  ii. Area of practice: Primary Care
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

PCMP: Rose Pediatrics

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Serve Pediatric Medicaid Patients

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☒ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Are you currently involved in the ACC program?

Please feel welcome to describe why or why not using the space below.

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☒ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.

- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings;

unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.

- So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
- Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
- There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and

"medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing 5DAC data is just one way to understand the activities within a medical home. 5DAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients
  b. Telephone consultation by a child psychiatrist to primary care providers

We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Core Coordination

Question 12) What needs for children/families should be coordinated in medical homes and are there services that should not be a part of core coordination by the pediatric and family medical home

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Our medical home relates to multiple RCCOs and we want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we could receive a pmpm from all of them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where should care coordination be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good

care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill? The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They

should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County
- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to

receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

- Since children are the majority and give the best chance of truly improving health and wellness, KPIs need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

<u>There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully.</u> Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and provider from medical homes to develop a vetting process that will enable HCPF and RCCOs to trust medical home self-reported real-time data.

- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd. Appropriate child health measures could be selected from the following measures :
    - Well child visits appropriate for age
    - Developmental screening by three years of age
    - Teen depression screening
    - Complete immunization status by age two
    - Post-partum depression screening rate for mothers of newborns by age 4 months
    - Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
    - Patient (or family) satisfaction ratings
    - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 022

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name:

1st Allergy and Asthma and Pediatrics
DBA Horizon Pediatrics and Primary Care
3566 E 104th Ave

Thornton, CO 80233

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization:

Location:

☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Pediatrics and Family Medicine
  ii. Area of practice: Thornton and Denver
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

I have worked with Molly Markek and her team. I also work as an advisor to CCHAP

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

I have cared for children on Medicaid since 1978 first in Metro NY and now 16 years in Colorado.lick here to enter text.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☒ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.

- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.
    - So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
    - Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
    - There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and

family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of

evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing SDAC data is just one way to understand the activities within a medical home. SDAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients
  b. Telephone consultation by a child psychiatrist to primary care providers
  We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Core Coordinatian

Question 12) Whot needs for children/fomilies should be coordinoted in medical homes and are there services thot should not be o part of core coordinotian by the pediotric and fomily medicol home

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...),

collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Our medical home relates to multiple RCCOs and we want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we could receive a pmpm from all of them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where should core coordination be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill? The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special

healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County
- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

- Since children are the majority and give the best chance of truly improving health and wellness, KPIs need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully. Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate

outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from

medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and provider from medical homes to develop a vetting process that will enable HCPF and RCCOs to trust medical home self-reported real-time data.

- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd. Appropriate child health measures could be selected from the following measures :
  - Well child visits appropriate for age
  - Developmental screening by three years of age
  - Teen depression screening
  - Complete immunization status by age two
  - Post-partum depression screening rate for mothers of newborns by age 4 months
  - Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
  - Patient (or family) satisfaction ratings
  - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	

1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 023

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

Littleton Fire Rescue
2255 West Berry Avenue
Littleton, Colorado 80120
303-795-3800 : Fax 303-795-3929

Proudly serving the communities of:

City of Littleton
Littleton Fire Protection District
Metro Districts Highlands Ranch

To whom it may concern,

The Littleton Fire Department utilizes advanced life support transport ambulances, a community paramedic program, and a mobile integrated healthcare response car that utilizes a physician assistant and a paramedic. From this perspective, the Littleton Fire Dept would like to provide a response to the RCCO RFP along two key lines of action, alternative destination and reimbursement modalities.

RCCOs should actively engage to support the utilization of alternative destinations for patients accessing the 911 system for behavioral health and non-emergency care issues. Chronic pain management and medication management issues deserve more targeted support to ensure the patient gets what they medically require, without taxing a 911 system that should remain available for higher acuity emergencies. In order to best address these alternative destination options, reimbursement modalities must also be in place.

Currently, ambulance services are financially rewarded for continued utilization of emergency department as the only destination for all 911 calls. In fact, the only financial recognition that the 911 system receives is for transport to the emergency department. The catch-all has become, in essence, that a call to 911 results in a high fee-for-service ambulance transport to the expensive emergency room evaluation. RCCOs need to engage in substantive alternative reimbursement structures that reward re-navigation of these care and behavioral health patients into the most appropriate, more affordable patient destination locations.

We appreciate the opportunity to provide input into the RFP from the perspective of the catch-all 911 system. Our agency exists to represent the needs of our public, to include the most effective access to the appropriate levels of care and cost-affordable alternatives to the existing system. Please do not hesitate to contact us for further questions or input regarding this perspective.

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Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 024

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Cyndi Dodds
Location: Fort Collins, CO 80525

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Touchstone Health Partners
Location: Larimer County, CO
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Community Behavioral Health Provider

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Member of the community leadership team and provide purchased staff with behavioral health expertise to the RCCO community care management team.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Colorado Medicaid provider, former BHO co-owner, current BHO subcontractor providing both mental health and substance use disorder treatment services

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

☒ Since before the program was implemented

General Questions

- What is working best in the Accountable Care Collaborative (ACC) right now?

The ACC model allows for flexible, community based, local approaches to care coordination that involve multiple partners and stakeholders.

The RCCO in our region has a well functioning multidisciplinary care coordination team that combines:

- physical health and behavioral health expertise
- access to multiple electronic medical records including a local hospital and several practices
- patient support at the point of care
- active leadership and strategic direction from the RCCO, practices, hospital, behavioral health organization and health district
- shared financing structure supporting the community care coordination team

- What is not working well in the ACC Program?

- What is working best in the Behavioral Health Organization (BHO) system right now?

The BHO system has successfully managed a risk-based global payment system. Through this model, the BHOs have established comprehensive networks of local, regional and state wide partnerships to provide flexible services that meet the unique needs of clients/patients in *their* community in a person-focused, integrated healthcare delivery system.

The "carve In" model of behavioral healthcare services has ensures over the years that designated funds are invested in medically necessary mental health services. Care must be taken in the future to ensure that behavioral health dollars continue to flow to provide these specialty services that ensure local flexibility, service coordination and distinction as appropriate and necessary to implement and operationalize a truly integrated system of care.

- What is not working well in the BHO system?

The BHO system is so heavily regulated that clinicians spend an inordinate amount of time on documentation and data collection. The system is not client-centered, it is bureaucratic/ administrative centered. Data is important, but it has to be more balanced. Access to services is critical and behavioral health centers are striving to manage a record demand for services. In order to reduce costs and increase efficiencies, including

access to care and service delivery, all systems need to be aligned to gather needed data while building efficiencies with emphasis on what is best for the clients/patients.

- What is working well with RCCO and BHO collaboration right now?

  Locally the RCCO, Rocky Mountain Health Plans, has been an outstanding partner utilizing a community engagement model that formally brings multiple systems together including the community mental health center, the BHO, medical practices, the local Health District, the Health Alliance of Northern Colorado etc. This approach has recognized that health care is local and to meet the goals of the RCCO multiple partners need to be aligned in the coordination and delivery of care.

- What is not working well with RCCO and BHO collaboration right now?

  To date, the RCCO and BHO have not shared cross system data to assure complete and accurate information in tabulating the system's impact on KPI's. In addition, divergent and burdensome administrative requirements limits the BHO's scope of practice and inclusion in primary care settings.

Behavioral Health Integration

- What should be the next steps in behavioral health integration in Colorado?[1]

  It is important that commercial health insurance plans, RCCOs and the BHO's are all aligned with Colorado's State Health Innovation Plan. Overall the focus should be on a system that focuses on what best serves the needs, both for medical and behavioral health, of the client/patient population including data systems, finance and provider quality and efficiency. Administrative requirements should provide the necessary regulatory and monitoring oversight to meet regulatory requirements while focusing on client/patient satisfaction including improved health outcomes.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

- **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	There should be consideration given to recognizing behavioral health as healthcare and not social services. This could include an examination of the current structure of behavioral health services being divided across multiple governmental systems rather and the inconsistencies that prevail regarding regulatory burdens and unfunded mandates imposed on behavioral health and not general healthcare.
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☒	☐	Work to more closely align 42CFR with HIPAA
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☒	☐	Staffing needs are an ongoing challenge for behavioral health providers
State/Federal rules or reporting requirements	☐	☐	

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Codes for billing integrated behavioral health services provided in a primary care practice need to be opened/authorized in Colorado		

- What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

  Please see Heath B, Wise Romero P, and Reynolds K. A review and Proposed Standard Framework for Levels of Integrated Healthcare, Washington, DC. SAMSA-HRSA Center for Integrated Health Solutions. March 2013.

- Please share any other general advice or suggestions you may have about behavioral health integration.

It is imperative that the state authorize billing codes that will allow for payment of behavioral health (mental health and substance abuse) services provided in fast paced medical practices and available to a broad range of symptom acuity presented by the individual patient. This could also be connected to cross system payment reform such as value-based global payment with performance based contracting for integrated health care.

Consistent with community partnerships and resources, providers should implement integration per the model referenced in question #9. Recognizing the uniqueness of communities, existing partners should join to agree upon an evolving system of integrated care.

Care Coordination

- Care coordination is an important part of the ACC Program.

  - What is the best definition of care coordination?

  A client centered assessment-based, trans-disciplinary approach that works with patients, their providers and their support systems to develop and implement a comprehensive care plan that integrates available physical health, behavioral health, social support services and self-care that are determined to have the best chance of maximizing a patient's health. Care coordination is done according to the patient's needs, goals, and preferences (with provider input.) Care coordination monitors progress and coordinates communication between all providers.

  - How should RCCOs prioritize who receives care coordination first?

  Some potential strategies for bending the health care cost curve and reduce costs include:
  - targeting patients having 4+ emergency room visits and great than $3,000 in potentially preventable events, and/or 10+ emergency room visits (excluding) clients whose emergency room visits are appropriate due their condition
  - Referrals from practices for high risk patients
  - Clients with evidenced-based conditions/issues such as asthma, post-acute stroke patients, complex frail elderly living independently and high risk/high cost medication management

  - How should RCCOs identify clients and families who need care coordination?

  - How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

  It would be ideal if RCCOs could develop a streamlined process that draws from already existing data instead of creating yet more reporting requirements.

- What services should be coordinated and are there services that should not be a part of care coordination?

Minimally coordination of physical health, behavioral health, social support services and self-care that is determined to have the best chance of maximizing a patient's health should occur. Coordination needs to be flexible enough to meet the unique needs of the patient and their families.

- What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

- Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

    - What care coordination is going on today?

    - What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

    Community Behavioral Health providers understand that the social determinants of health play role promoting a client/patients recovery and resiliency. Care coordination is provided to ensure clients have services to meet their needs so that treatment can be effective and recovery possible. The community mental/behavioral health system has been skilled at providing case/care management services to support their clientele's treatment and recovery for decades. Capitalizing on this experience is an important feature that can support primary care practices with whole person care.

    - How can the ACC avoid duplicating or disrupting current care coordination relationships?

    - What are the gaps in care coordination across the continuum of care?

    Who is going to coordinate the multiple care managers? Consistency is key in being successful in improving outcomes and the client/patient experience in the treatment and management of their healthcare and related needs.

- **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☒	Touchstone Health Partners has a large variety of robust partnerships with other community services including Child Welfare, Foot Hills Gateway, the Work Force Center, Schools, the Criminal Justice System including the local jail & community corrections, probation & parole, law enforcement, the Health Department & Health District of Northern Larimer County, private providers etc.

Affordability (assistance with prescriptions or co-pays)	☒	☐	☐	
Daycare / childcare	☐	☐	☒	
Economic stability & employment	☐	☐	☒	
Education	☐	☐	☒	
Environment	☐	☐	☒	
Food access / nutrition	☐	☐	☒	
Health literacy	☐	☒	☐	
Housing	☐	☐	☒	
Language or translation services	☐	☐	☒	
Literacy	☐	☐	☒	
Transportation	☐	☐	☒	
Other	RCCOs should coordinate with local behavioral health centers and BHOs around needed mental health and substance use disorder services.			

- **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	
Certified Addiction Councilors	☒	☐	
Certified Nurse Midwives	☒	☐	
Community Health Workers	☒	☐	

Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☒	☐	
Licensed Mental Health Counselors	☒	☐	
Licensed Professional Counselor	☒	☐	
Masters of Public Health	☒	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	
Nurse Practitioners	☒	☐	
Patient Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☒	☐	
Psychiatrists	☒	☐	
Psychologists	☒	☐	
Registered Nurses	☒	☐	
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	
Other	Any of these categories could play a strong role on a multidisciplinary care coordination team. It is important to keep any requirements flexible to meet local community needs.		

- **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☒	☐	

Children involved in the foster care system	☒	☐	
Children with a chronic illness	☒	☐	
Children with a serious emotional disturbance	☒	☐	
Children with medical complexity	☒	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☒	☐	
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	
Clients involved in the criminal justice system	☒	☐	
Clients with a disability	☒	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☒	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

- How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

- How should care coordination be evaluated? How should its outcomes be measured?

- Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

    - What is the PMPM cost for providing care coordination services?

    - Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

- Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

    - **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☒
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

- How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

- Please share any other general advice or suggestions you have about care coordination in the ACC.

The ACC should streamline regulations and allow for flexible, community based models that are done at the point of care.

Program Structure

- If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

- The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

- Should the RCCO region maps change? Why or why not? If so, how?

Regional maps should align with patient patterns in accessing care build upon natural partnerships.

- Should the BHO region maps change? Why or why not? If so, how?

No, the current boundaries are well established, highly functional, support patient patterns for accessing care and build upon natural partnerships.

- Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

There is a danger in asking local communities to move through a RCCO transition. There has been a tremendous investment of time and talent from key stakeholders in planning, implementing, adjusting and maintaining RCCO initiatives. To think that this type of work might have to be recreated with new partners in the near future is exhausting, disruptive and pulls much needed resources away from patient/client care.

- What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

- What are the limitations of the current benefit structure and what – if any – changes are needed?

- Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

No, this would lead to a highly fragmented community response resulting in multiple care coordination teams, miscommunication, duplicated efforts and confusion for patients and practices. Communities would coordinators to coordinate the care coordinators.

- If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

- What role should RCCOs play in attributing clients to their respective PCMPs?

Attribution should be based on the patient's needs and access to care.

- What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

- What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

  The ACC Program and the Dept. of Human services should be closely aligned to ensure that both systems are funded adequately and are highly coordinated to ensure high quality and effective care for all Coloradoans.

What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

- What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

It would be helpful if DORA could ease/improve the incredibly difficult process of licensing psychiatrists and psychiatric nurse practitioners that have practiced/move here from another state.

Stakeholder Engagement

- What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

- What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

- Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

- How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

- Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

    a. If no, what are the gaps?

    b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

    No, Colorado has a shortage of psychiatric providers, epically those serving children/youth.

    ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

    The scope of practice of mid-level practitioners should be reviewed for expansion in order to ensure that their skills and training are fully utilized. Reciprocity agreements either other states should be reviewed to more rapidly credential recruits from other states. Colorado should incentivize out of state recruits rather than discouraging them from practicing in Colorado.

- What role should hospitals play in the next iteration of the ACC Program?

- What role should pharmacies play in the next iteration of the ACC Program?

- What role should specialists play in the next iteration of the ACC Program?

- What role should home health play in the next iteration of the ACC Program?

- What role should hospice care play in the next iteration of the ACC Program?

- What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

- What role should counties play in the next iteration of the ACC Program?

- What role should local public health agencies play in the next iteration of the ACC Program?

- What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

- How can RCCOs help to support clients and families in making and keeping appointments?

Easily accessible transportation

- Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

Community Health Workers or Patient Navigators should be supported but not required. Allow for flexibility in the ACC model.

- **Community Health Worker reimbursement**. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

- Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

- Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.
    - What does cultural competence mean to you?
    - What RCCO requirements would ensure cultural competency?
    - What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?
    - Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

    Bidders should demonstrate that they can deliver care in a culturally informed, appropriate and competent manner.

- Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

- Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Real time data is needed to provide timely intervention. The ACC should support a process for alerting a practice when their patient enters the emergency room. Public information campaigns that inform about alternative care options might also be useful.

- Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

- **Support for practices**. Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

- If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

- What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

- What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

Providers should be incentivized to assume/manage risk.

A policy of having a part of a contract withheld with providers required to earn it back is an ineffective incentive program.

- Should the Department require that PCMPs utilize disease registries to manage the health of their population?

- Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

- Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

Move away from fee for service (ffs) models to those where the RCCO assume and manage risks. FFS models do not support comprehensive integration. The current BHO capitation model is actually a FFS model that is disguised a global payment/capitation model. The requirement to justify payment and avoid "claw back" or rate reductions is through a unit of service accountability structure results in restricting service options that are unreimbursed even though they are effective in achieving health outcomes. This includes some categories of care coordination, technology delivered services, consultations without the client/patient present etc.

- If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

- Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

- The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

- What role – if any – should the RCCOs play in the distribution of payments to providers?

- Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of cli Providers should be incentivized to assume/manage risk ents and providers, and health outcomes?

- **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

- Knowing that, at this time, the Department only has claims data, how should population health be measured?

- How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

- **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

- What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

- Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

- Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Establish baseline performance using national standards and then reward improvements.

- Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

- **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

- For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

- For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Community Behavioral Health providers practice in the CSTAT measures for both mental health and substance use disorder services as part of their contract with OBH. There are also specialty programs such as Functional Family Therapy, Integrated Dual Disorder Treatment and Parent Child Interaction Therapy that have outcome measures that are not reimbursed.

Health Information Technology (HIT)

- **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

- **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

- **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☐
Care management tool	☐	☐	☐	☐	☐
Care transitions alerts	☐	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☐
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

- What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

- How can Health Information Technology support Behavioral Health Integration?

- In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

In order to support the whole person, it needs to include both behavioral health data and physical health data.

- Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

- Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

- Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

If we're going to connect the head and the body and provide truly integrated care, it will vital that both behavioral health and physical health providers are included in a directory.

- How can the RCCOs support providers' access to actionable and timely clinical data?

Real time clinical data is critical.

- What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

- What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

- What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

Health information exchange platforms need to support patient care and intervention at the practice/provider level with real time, easy to access data that includes both behavioral and physical health information.

- Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 025

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: David Pacini, MD

Location:

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Primary Care Partners

Location:

☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Pediatrics
  ii. Area of practice: Private practice, Western Colorado
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

2 yr

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Medicaid provider for over 20 yr

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☒ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.

- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive

care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.

- So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
- Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
- There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its

KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing SDAC data is just one way to understand the activities within a medical home. SDAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients
  b. Telephone consultation by a child psychiatrist to primary care providers

We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Core Coordination

Question 12) What needs for children/families should be coordinated in medical homes and are there services that should not be a part of core coordination by the pediatric and family medical home

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Our medical home relates to multiple RCCOs and we want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we could receive a pmpm from all of them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where should core coordination be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good

care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill? The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They

should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County
- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to

receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

- Since children are the majority and give the best chance of truly improving health and wellness, KPIs need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully. Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and provider from medical homes to develop a vetting process that will enable HCPF and RCCOs to trust medical home self-reported real-time data.

- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd. Appropriate child health measures could be selected from the following measures :
    - Well child visits appropriate for age
    - Developmental screening by three years of age
    - Teen depression screening
    - Complete immunization status by age two
    - Post-partum depression screening rate for mothers of newborns by age 4 months
    - Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
    - Patient (or family) satisfaction ratings
    - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 026

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

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THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Shannon M Murphy

Location:

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Primary Care Partners

Location:

☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty:
  ii. Area of practice: pediatrician
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Medicaid providier

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Provider and advocate for children on medicaid

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☒ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate

☐ N/A

Are you currently involved in the ACC program?

Please feel welcome to describe why or why not using the space below.

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
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☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.

- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings;

unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.

- So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
- Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
- There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and

"medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

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- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 961SS) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

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- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients
  b. Telephone consultation by a child psychiatrist to primary care providers

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We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Care Coordination

Question 12) Whot needs for children/families should be coordinated in medical homes and are there services thot should not be o port af care coordinotion by the pediotric ond family medical hame

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordinatian in the ACC.

Our medical home relates to multiple RCCOs and we want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we could receive a pmpm from all of them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where shauld core coordinotion be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good

care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill? The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They

should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County
- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to

receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

- Since children are the majority and give the best chance of truly improving health and wellness, KPIs need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully. Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

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- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd. Appropriate child health measures could be selected from the following measures :
  - Well child visits appropriate for age
  - Developmental screening by three years of age
  - Teen depression screening
  - Complete immunization status by age two
  - Post-partum depression screening rate for mothers of newborns by age 4 months
  - Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
  - Patient (or family) satisfaction ratings
  - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 027

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Ellen Brooks, MD

Location:

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Pediatric Partners of Valley View

Location: 1905 Blake Ave. , Suite 201, Glenwood Springs, CO 81601

☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty:
  ii. Area of practice: Pediatrics
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

I have been intermittently involved with the CCHAP Advisory Board

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

We accept Medicaid patients and also see them in our local hospital

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☒ Likely
☐ Reserved (waiting to see the RFP)

☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

Please feel welcome to describe why or why not using the space below.

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☒ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.
- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.
- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.
- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:
    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.

- If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.
- So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
- Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
- There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

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b. Telephone consultation by a child psychiatrist to primary care providers

We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Core Coordination

Question 12) What needs for children/families should be coordinated in medical homes and are there services that should not be a part of core coordination by the pediatric and family medical home

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Our medical home relates to multiple RCCOs and we want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we could receive a pmpm from all of them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where should care coordinotion be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill? The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County
- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high

performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

- Since children are the majority and give the best chance of truly improving health and wellness, KPIs need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

<u>There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully.</u> Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

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- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd. Appropriate child health measures could be selected from the following measures :
  - Well child visits appropriate for age
  - Developmental screening by three years of age
  - Teen depression screening
  - Complete immunization status by age two
  - Post-partum depression screening rate for mothers of newborns by age 4 months
  - Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
  - Patient (or family) satisfaction ratings
  - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 028

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: William Findlay MD

Location: Grand Junction, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Western Colorado Peditrics

Location: Grand Junction, CO

☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty:
  ii. Area of practice: pediactrics, grand junction
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

1-2 yrs

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

our practice has served Medicaid for over 30 years

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate

☐ N/A

Are you currently involved in the ACC program?

Please feel welcome to describe why or why not using the space below.

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☒ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.

- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive

care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.

- So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
- Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
- There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its

KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing SDAC data is just one way to understand the activities within a medical home. SDAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients
  b. Telephone consultation by a child psychiatrist to primary care providers

We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

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This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

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Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

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Payment Structure and Quality Monitoring

S9) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to

receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

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60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

<u>There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully.</u> Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

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- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd. Appropriate child health measures could be selected from the following measures :
    - Well child visits appropriate for age
    - Developmental screening by three years of age
    - Teen depression screening
    - Complete immunization status by age two
    - Post-partum depression screening rate for mothers of newborns by age 4 months
    - Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
    - Patient (or family) satisfaction ratings
    - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 029

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: William M Campbell, MD

Location: Children's Hospital Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Children's Hospital Colorado

Location: Aurora, CO

☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty:
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

About 8 years, including the Children's Services Steering Committee

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate

☐ N/A

Are you currently involved in the ACC program?

☐ Yes
☐ No
☐ I don't know

Please feel welcome to describe why or why not using the space below.

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.

- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.

- So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
- Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
- There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing 5DAC data is just one way to understand the activities within a medical home. 5DAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients
  b. Telephone consultation by a child psychiatrist to primary care providers

We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

- Behavioral health care should be provided for children with developmental disabilities (e.g., autism spectrum disorder and intellectual disability, genetic syndromes, traumatic brain injury, fetal alcohol spectrum disorder, etc.) who also have behavioral health problems (e.g., anxiety, depression, bipolar disorder, disruptive behaviors, etc.)

Care Coordination

Question 12) What needs for children/families should be coordinated in medical homes and are there services that should not be a part of core coordination by the pediatric and family medical home

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Our medical home relates to multiple RCCOs and we want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we

could receive a pmpm from all of them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where should core coordination be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill? The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across

the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

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There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully. Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under

capitation. You have to help the medical homes create the habits you want before the switch to capitation.

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RFI Response 029

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

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Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 030

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Cassana Littler

Location: Grand Junction, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Western Colorado Pediatric Associates

Location: Grand Junction, CO

☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Primary Care
  ii. Area of practice: General Pediatrics
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Physician and medical home provider to families on the Western Slope of Colorado

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Medical home provider for Medicaid patients on the Western Slope

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☒ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Are you currently involved in the ACC program?

Please feel welcome to describe why or why not using the space below.

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☒ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.

- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings;

unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.

- So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
- Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
- There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and

"medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing SDAC data is just one way to understand the activities within a medical home. SDAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients
  b. Telephone consultation by a child psychiatrist to primary care providers

We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Core Coordination

Question 12) What needs for children/families should be coordinated in medical homes and are there services that should not be a part of core coordination by the pediatric and family medical home

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Our medical home relates to multiple RCCOs and we want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we could receive a pmpm from all of them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where should care coordination be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good

care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill? The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They

should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County
- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

Payment Structure and Quality Monitoring

S9) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to

receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

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60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

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    - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 031

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Lauren Carei, PA-C

Location: Western Colorado Pediatrics

3150 N. 12th Steet

Grand Junction, CO 81506

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Western Colorado Pediatrics

Location: 3150 N. 12th Steet

Grand Junction, CO 81506

☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
   i. Type or specialty: Physician assistant
   ii. Area of practice: Pediatrics
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

I am a physician assistant and I provide care to Medicaid patients on a daily basis.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

I am a physician assistant and I provide care to Medicaid patients on a daily basis.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☒ Likely
☐ Reserved (waiting to see the RFP)

☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

Please feel welcome to describe why or why not using the space below.

If you answered "yes" above, how long?

☐ Less than one year
☒ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.
- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.
- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.
- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:
    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.

- If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.
- So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
- Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
- There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing SDAC data is just one way to understand the activities within a medical home. SDAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:

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a. Assistance with finding a behavioral health provider for patients
b. Telephone consultation by a child psychiatrist to primary care providers
We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Care Coordinotion

Question 12) Whot needs for children/families should be coordinated in medical homes and are there services thot should not be o port of core coordinotion by the pediatric and fomily medicol home

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Our medical home relates to multiple RCCOs and we want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we could receive a pmpm from all of them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where should care coordination be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. **children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill?** The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County
- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high

performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

- Since children are the majority and give the best chance of truly improving health and wellness, KPIs need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully. Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and provider from medical homes to develop a vetting process that will enable HCPF and RCCOs to trust medical home self-reported real-time data.

- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd. Appropriate child health measures could be selected from the following measures :
  - Well child visits appropriate for age
  - Developmental screening by three years of age
  - Teen depression screening
  - Complete immunization status by age two
  - Post-partum depression screening rate for mothers of newborns by age 4 months
  - Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
  - Patient (or family) satisfaction ratings
  - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

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- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

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1-7	☒
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None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 032

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

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THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Claudia Jantzer

Location: Grand Junction, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization:Western Colorado Pediatrics

Location: Grand Junctiion, CO 81503

☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty:
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:Provider for Patients.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☒ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
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☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.

- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive

care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.

- So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
- Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
- There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its

KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing SDAC data is just one way to understand the activities within a medical home. 5DAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients
  b. Telephone consultation by a child psychiatrist to primary care providers

We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Care Coordination

Question 12) What needs for children/families should be coordinated in medical homes and are there services that should not be a part of care coordination by the pediatric and family medical home

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Our medical home relates to multiple RCCOs and we want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we could receive a pmpm from all of them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where should care coordination be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good

care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or **chronically ill?** The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They

should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County
- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to

receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

- Since children are the majority and give the best chance of truly improving health and wellness, KPIs need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully. Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and provider from medical homes to develop a vetting process that will enable HCPF and RCCOs to trust medical home self-reported real-time data.

- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd. Appropriate child health measures could be selected from the following measures :
  - Well child visits appropriate for age
  - Developmental screening by three years of age
  - Teen depression screening
  - Complete immunization status by age two
  - Post-partum depression screening rate for mothers of newborns by age 4 months
  - Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
  - Patient (or family) satisfaction ratings
  - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 033

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Anita Rich
Location: Aurora, Adams, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Children's Healthcare Access Program
Location: aurora, Adams Colorado
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☒ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☒ 3-4 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Contracts with a several RCCOs, participate on RCCO and State Advisory Boards, train and support primary care Pediatric and Family practices with Care Coordination and practice growth(transformation).

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Support Practices to help clients maintain their Medicaid eligibility, Sit on Children's Service Advisory Committee, used as an expert on the needs of children and Medical Homes for Children, and helped with the certification of Medical Homes for Children in Colorado.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☒ N/A

Please feel welcome to describe why or why not using the space below.

☒ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

2) What is not working well in the ACC Program? **Practices report to me that the Attribution process is difficult to understand, use and correct. Many Pediatric practices still have adults on their list they have no knowledge and do not seem to be able to remove. Even though processes are followed (given to them by the RCCO) the adults are not removed timely. Sending lists and creating spread sheets are tedious and time consuming. Practices do not have this time or expertise. Attribution needs to be fixed to create a simple way to add and remove members.**

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now? **They are involved in separate regions. Regions should be identical to ensure collaboration and improved practices between the efforts for both organizations.**

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1] **Not talk about Integrating Behavioral health, but in a wellness model, talk about integrated Preventive Care. This could include physical, behavioral, and oral care. Why do they need to be in separate siloes to work at having the integrated in a practice?**

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☒	☐	Solve the problem as to whose patient is this and who is the primary care provider. With $3PMPM every one wants to be the primary.
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	Solve the release of information problem between the two different systems so the patient's needs and health are primary not the systems. All done with the patient as the focus.
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☒	☐	Always
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☒	☐	PHI See Above
Technical resources / data sharing	☒	☐	PHI issues
Training	☒	☐	

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Others	Please type your response here.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care? *Rewrite How obout integrated, whole-person/whole fomily core?*

Colorado Medicaid wants to move toward integrating behavioral (mental) health into the child's medical home. Practices will need work force help and a sustainable payment model. The ACC program needs to set standards and enforce consistency across the RCCOs and BHOs. Standardization in payment for services and for co-located providers, standards in information sharing and documentation, and standardization in timeliness of treatment as well as extended hours for treatment will be helpful.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

How do we merge integrated behavioral health with Care Coordination and risk assessment and care, so that so issues can be referred out and followed?

How will the RCCOs support the needed work force development? To integrate you need the expertise with in the practice for identifying need and the folks trained and integrated to meet the need. How are we going to train/help the staff get to the point to support a family and to help them to understand the need they have for services? This issue should be a focus of the next RFP how to train and pay for these services in a sustainable manner.

Care Coordination

Colorado Medicaid wants to move toward integrating behavioral (mental) health into the child's medical home. What would that look like in your practice? What do you need in order to move in that direction? Where should care coordination be done?

___x__ In your practice?
_____ In your community close to your practice, run by a community-based organization
_____By the RCCO in your region

How willing are you to provide care coordination in your practice?

Practices tell me that they would like to have Care Coordination for children provided as close to the patient and family as possible. Integrated services in many forms, behavioral health, oral health, health literacy, food pantries, clothing, internet access, all could be provided to patient within the primary care practice. Levels of service would depend on panel mix and the needs of practices and the patient/familiesthey treat. All services would need appropriate levels of financial support for practice to provide these non-billable services.

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination? **Care Coordination is an organized/structured set of activities to support a child receiving the appropriate services and resources necessary to achieve the best results necessary. These services are provided in a patient/family centered way which includes assessment of needs and strengths, a developed care plan and goals focused on the family and follow up on activities in the plan to be sure that needs were met or support services provided so that services stay focused on the needs identified by family.**

b. How should RCCOs prioritize who receives care coordination first?

High on the list need to be referrals from provider and practice staff, patients/families needing high levels of specialty care, premature infants, long term care services and palliative care, children and families needing waivers and children not showing up for their appointments. The request for the patient/family for help should also be concerned high on the list.

c. How should RCCOs identify clients and families who need care coordination?

I believe the effort and staff hours should go to those patients/families where change can be made such as NEMT issues, no show issues, lack of resource issues. High dollar ED users can be supported but I wonder if the RCCO gets the most bang for their buck working services for one client rather than ten. Would it be better to work with Community agencies, with maybe financial support given to them, and use RCCO staff to deal with other less intense issues?

Believe providers when they call and not brush them off with a resource to call. Serve the provider and the client!

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider? **Monthly activity reports, case audits done on the same level as RCCO staff audits, on-site supervision as well as case consultation for those difficult situations that occur.**

12) What services should be coordinated and are there services that should not be a part of care coordination? **In a whole person approach, it should be those things that effect health from birth to end of life care. Support should be based on a needs assessment and on those services identified by the patient/family important and helpful to them and their success. Anything that will effect a patient's/family's wellness and ability to function is fair game for care coordination.**

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs? **Need is determined by the patient and family. A needs assessment done with the family is basic in determining what direction and services will improve the health and well being of the system. Care Coordination is basically build on relationship and that relationship must be develop in a trust filled, patient centered, supportive environment.**

Basic information needs to be collected and the plan should be a joint, patient care coordinator developed plan.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today? **I am not sure of the extent of Care Coordination that is going on, whether formal or informal. As Assessment occurs this needs to be explored for each patient/family.**

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different? **Takes place in school, non-profit organization, religious organizations, between friends and in families to name a few. These informal and formal relationships need to be supported and nurtured. We are looking for results that lead to better lives, not credit for who did something.**

c. How can the ACC avoid duplicating or disrupting current care coordination relationships? **Allow providers to help patients and families and intervene to support the work closest to the patient**

and in the patient/families community. RCCO centric care coordination is distant for the patient/family and not in tune with the system that the patient/family currently functions.

d. What are the gaps in care coordination across the continuum of care? **There is a lack of understanding particular systems and a lack of relationship in the non-delegated system being created. It has lost its personal touch in most instances. In the pediatric system, there are gaps in hospital to community, particular for preemie babies, interaction with schools and day care, developmental screening and treatment, transportation support, health literacy, and transition to adulthood. All vital for the successful growth of children.**

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	Should the RCCO have a role? No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☐	Reporting abuse and neglect, both child and elder and supporting the investigating agencies and helping with needed services not be ing provided by another agency.
Affordability (assistance with prescriptions or co-pays)	☒	☐	☐	Don't assist everyone, but have resources so that needed help can be obtained and the provider's identified services can be received.
Daycare / childcare	☐	☐	☐	Referral sources and help connecting to them
Economic stability & employment	☐	☐	☐	Referral sources and help connecting to them
Education	☐	☐	☐	Referral sources and help connecting to them
Environment	☐	☐	☐	I am not sure what this means.
Food access / nutrition	☐	☐	☐	Referral sources and help connecting to them
Health literacy	☒	☐	☐	Support practices with needed materials or development help and modalities for delaing with the problem in the practice.

Housing	☐	☐	☐	Referral sources and help connecting to them
Language or translation services	☒	☐	☐	RCCOs should support practices with easy and inexpensive ways to obtain immediate interpretation and translation of documents.
Literacy	☐	☐	☐	Referral sources and help connecting to them
Transportation	☒	☐	☐	Make sure that resources are available in all areas of the RCCO
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	**Coordinate care? Yes**	**No**	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☒	☐	Complicated medical care possibly for individuals being discharged from institutions and hospitals to insure Discharge plans are in place and the family the education and equipment they need to implement them. Also to monitor situation for a while to ensure that care is bing carried out.
Certified Addiction Councilors	☐	☒	
Certified Nurse Midwives	☒	☐	In OB Gyn office only
Community Health Workers	☒	☐	Practical feet on the ground; helath literacy helpers; follow up; know neighborhood and community resources
Generalists (BA/BS/MA/MS)	☒	☐	Best choice; know alittle about a lot, good problem solvers
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☒	☐	Possibly for supervision; can also do behavioral health, grief/loss and palliative care.
Licensed Marriage and Family Therapist	☒	☐	See above
Licensed Mental Health Counselors	☒	☐	Need to be generalist good at all ages, see LCSW
Licensed Professional Counselor	☒	☐	See above
Masters of Public Health	☐	☒	

Medical Doctors / Doctors of Osteopathic Medicine	☐	☒	
Nurse Practitioners	☒	☐	In extremely complex medical or psych situation
Patient Navigators	☒	☐	Can provide very practical information to patients, help with health literacy, know area
Peer Advocates	☒	☐	Can help with practical information on community; can make calls and set up appointments
Promotoras	☐	☐	
Psychiatrists	☐	☒	
Psychologists	☐	☒	
Registered Nurses	☒	☐	Doing this work now
Social Workers	☒	☐	See LCSW
Wraparound facilitators	☐	☐	I don't know what these are, but might be lik Peer Advocates
Other	Please type your response here. School personnel, religious organizations and friends and family. Left off this list above are all the informal community folks that do most of this work. Grandparents, friends, neighbors, pastors and church members. Don't get stuck in this is only a PROFESSIONAL response.		

17) **Care coordination requirements** for specific **populations**. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☒	Preemies, born with equipment needs, O2, genetic abnormalities
Children	☒	☒	Above children older, blind, hearing loss, developmental delays, foster care
Children who are healthy, but in socially-complex environments	☐	☒	
Children involved in the foster care system	☒	☐	Legal, parental and behavioral issues as well as all the developmental issues of children and teens need special care and knowledge
Children with a chronic illness	☒	☐	Special knowledge of complex medical conditions, waviers, equipment, respite is necessary
Children with a serious emotional disturbance	☒	☐	Considered complex care need to understand needs of child and family

Children with medical complexity	☒	☐	See above in chronic illness
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	See above in emotional disrtrubance
Transition-age adolescents	☒	☐	Persuading adult providers is hard
Parents and families	☒	☐	Need to understand family dynamics
Pregnant women	☒	☐	Complicated medical situation
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

Working in a collaborative mode with anyone connected with the patient. RCCO staff will need to learn about the legal and temporary nature of foster care and residential care and support schools; behavioral health and physicians in helping the child receiving care have a good care plan and make sure that plan follows the patient

19) How should care coordination be evaluated? How should its outcomes be measured?

There should be the development of process and clinical outcomes the show that care is happening. The measurements should be the same for delegates and RCCO care coordinator, any model of care coordination being provided by the RCCO. All patients should be assured they are receiving high quality planning and results no matter where their support and help is coming from.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

I believe there should be a basic payment for care coordination. This would cover the cost for monitoring, data support, and "being ready for anything. Cost $3-$4 PMPM

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

Yes, acuity is important and costly Complex medical and social situations need more time, possibly travel and much more clinical knowledge to ensure positive outcomes. Cost $4.50 to $5 PMPM for high CRG patients and families.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population? **YES**

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

I base this answer on a mixed caseload of acuity as any practice would be. Caseloads should be monitored and even though a caseload can be up to 100, those limits don't always allow the best care. Supervision is important sand should be monitoring outcomes, worker ability and stress levels and at times modify the numbers. This is not a program about numbers it is a program about outcomes, patient satisfaction and worker stability.

Clients	
Fewer than 25	☐
26-50	☐
51-100	☒
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

The triple aim. Use care plans and goal attainment. Measurement will have to start with process outcomes, but as folks become more proficient outcomes could be decreased no shows, patient satisfaction, use of community resources, collaboration, care plans completed, increase immunization rates, fewer days missed from school and graduation rates of students.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Care Coordination is best done where the child and family go for care, not over the phone miles away. Success lies in relationship not referral. Simple care plans should exist for all children with identified needs. Put care coordinators where children can be reached and have them collaborate with all those services involved with the patient.

Create systems where the legal needs of patients and families are supported. Housing needs, custody , violence, disability, school, and the acquisition of services are vitally important.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

All the things mentianed in the question are important for consistency. Borders between RCCOs are nonexistent to potients and no one should miss out on services becouse they see o pravider in anather RCCO. This program is PATIENT and FAMILY CENTRIC nat RCCO centric. This hos to be the center af oll decisions.

Functions: No function af o RCCO should look different to the customer, specialists, providers, potients, and fomilies moving from one ploce to another. If the service touches a custamer it MUST look and feel the some such os accessing services, contacting services, receiving services. Internolly RCCOs can be different, but a custamer should never hear "thot is not my practice, we don't da thot, or you will have to call this number."

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

They need to be in state company. A company that has experience with Medicaid clients and not in the business to promote anything, but good quality service is important. They should also have their office in the Region thy support. I would suggest that the hire folks that live in the region also. If possible, hire staff that has had to use services in the regions for their own needs. Give the RCCO a local feel.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This idea would certainly make the program more provider and patient centric than RCCO centric. it promotes service provision rather than infrastructure development. Instead of the RCCO doing everything a partnership would need to be developed with the practices and a more collaborative from a far plan would need to occur. It would be interesting.

This would also require the administrative part of the ACC to set manumit basic standards for all RCCOS. This might encourage RCCOs to put their emphasis on service provision.

The first RFP was looking for different approached for this program form the different RCCOs. Now, I think the basics of Administration and service provision should be mandated by HCPF and aloe the RCCOs to focus on patients and family needs and stopping developing infrastructure. Have the foundation developed by HCPF and all RCCOs adhere to that and develop up from that base to caring for its population.

27) Should the RCCO region maps change? Why or why not? If so, how?

I might be more efficient have them a line with the BHOs, if the BHO system remains. If not, the change I suggest is that Larimer County become part of the Front Range system instead of Region 1. It has more connections there.

28) Should the BHO region maps change? Why or why not? If so, how? **See above**

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

I have no idea how much it would cost. It would take a year, at least, if the company did not already have an infrastructure. All data, relationships and materials would have to transfer. There should have to be no hard feelings as this occurred. Both entities would have to have great integrity and understanding.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

Improve attribution, decrease the time lag for data (not four months behind) , provide for the ability to pull reports on particular topics and stop adding things for everyone to do for a while. I understand that we are always after funding, but no one has time to adjust and look at results before we are moving on to something else.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

I think this is possible. See #27. This would bring this situation into being. Already any practice can have a number of RCCOs to deal with. Competition might improve the current situation, but not at the expense of the practice and the patient/family.

Once a Provider contracts with the RCCO they need to be seen as contracting with every RCCO. The idea that this practices is mine and that one is yours is RCCO centric, not patient/family centric. That idea needs to change. Confusion does rain in the community resource and nonprofit world.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs? **The same as they are doing now. They should not be in the business of assigning patients.**

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services*? Around common patients/families*

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

How about the Department of Education and every school district? Please stop leaving out children and their work.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates? **They should continue to solicit input. They ca not do this work alone.**

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole? **Maintain Advisory groups, but use them for advice instead of reporting activities to them. These groups must be active participants and their view points be seen supportive and helpful. They may have ideas to make the program better. Use these folks as subject experts and advisors instead of once a quarter meeting attenders.**

How involved are you with the RCCO? How willing are you to be involved with the RCCO? What do the RCCOs need to do to get you interested in getting involved? **I am very active. I want to stay that way. I think that this movement can grow to really improve health and controls costs.**

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps? **Hospitals are not participating. They all must participate to make this effort work successfully.**

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities. **Children and their families are not a sub population, but currently are being treated that way. The emphasis has been going to "where the money is" to keep the RCCO functioning. You want to put an emphasis on whole person preventative care, look at you youngest members and don't think of them as a sub-population. They are the majority of your members.**

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments? **Should be done in the practices part of the Care Coordination if PMPM will support it.**

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP? **No, if we provide Care Coordination at the practice, the practice needs to decide how is is going to do that. CHWs are a good choice if paired with others. PMPM should be enough to defray the expenses of CHW.**

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☒

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers? **Oral health is another service that should be integrated into practices. Services can be still administered the way they are now. Oral health is mandatory in all integrated care.**

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families. **See paragraph below.**

The Jaint Commissian hos identified the following 3 challenges as the "triple threot" to healthcare communication: 1. Longuoge borriers 2. Cultural borriers, 3. Low health literocy borriers.

Each RCCO must have a comprehensive strotegy to address effective communication (oral and written) with limited English ond culturolly different patients/families os well os those with low health literacy. What is your "argonization's" strotegy for addressing the triple threot on these three levels:
1. Building owareness af the "triple threot" to healthcore communicatian (1, 2, and 3 listed obave)
2. Identifying ond addressing systemic solutions to heolth literocy (signoge, website readability, handauts, phone trees, communicotians to potients, care coordination).
3. Implementing education/troining for providers ond staff in private practice and clinic settings in your regian to improve cammunicotians skills that lead to better health outcomes for all patients.

a. What does cultural competence mean to you? *See above*

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support: **See answer below the grid.**

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others	There are so many programs being funded to provide practice support, SIM, CHES and now TCPI, I believe the question is not what to provide, but how does the ACC fit into what is available to practices and not flood the practices with helpers from each for these initiatives. How can the			

programs work in collaboration with a single goal in mind and split up the work? All the tools and supports are great, but the process of helping practices will not be welcomed if the programs look uncoordinated and non-collaborative. Let's work together.

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes? **See Above**

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population? NO . **Some practices cannot afford it.**

58) Please share any other advice or suggestions about provider support in the ACC.

Remember these practice are private businesses. You want to support them and not push them out of the program. Why don't RCCOs work with practices to make this plan?

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

Right now medical homes don't get rewards for good outcomes, unless the whole RCCO has the good outcomes. Is this fair? Or should a practice get rewards for good performance no matter how well the RCCO does?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☒

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☒
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☐	☒
Smartphone app	☐	☒
Other: ALL formats are necessary to address specific needs that the other formats cannot; that's why they're there.		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the 5DAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☒	☐	☐	☐
Care management tool	☐	☐	☒	☐	☐
Care transitions alerts	☒	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☒	☐	☐	☐	☐
Health risk assessment software	☐	☒	☐	☐	☒
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☒
Patient education wellness tools	☐	☐	☒	☐	☐
Provider/case manager directory	☐	☒	☐	☐	☐
Shared decision-making tools	☐	☒	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☒
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Possessing outdated tech (eg Windows XP, Office 2003), or next-to-no tech at all

Inability to use basic office management software (ie MS Office)

The Attribution algorithm is faulty; FIX IT. KEEP ADULTS OUT OF PEDIATRIC PRACTICES

Liability anxieties create inter-agency barriers related to sharing PHI

Releases are not standardized across Medicaid entities.

81) How can Health Information Technology support Behavioral Health Integration?

Improving assessment and identification of needs that lead to/exacerbate behavioral health issues

Reducing duplication of work; increasing real-time connections between providers

Improving security, enhancing communication, reducing cost, increasing user satisfaction

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

YES. Needs to have more data and greater end-user flexibility. It should allow end-user customization to accommodate diverse needs

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

YES. System could be similar to BUS, TRAILS, EPIC, etc. Standardization is VITAL to ensure consistency across providers, regions, and to improve audit efficiency

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

Standardization is VITAL to ensure consistency across providers, regions, and to improve audit efficiency

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

Current functionality is sufficient, although mobile-optimization would be good. Regular updates (by providers for HCPF) should be required

86) How can the RCCOs support providers' access to actionable and timely clinical data?

Require HCPF to include more data and end-user functionality in the SDAC
Update ALL data every month (disregard 120-day timely filing delay)
MAKE HCPF FIX THE ATTRIBUTION ALGORITHM; INCORPORATE PEDIATRIC PRACTICE INFORMATION TO ELIMINATE ATTRIBUTION OF ADULTS TO PEDIATRIC ROSTERS

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

Standardized, regular, ADT info from hospitals
Standardized ROI for use by all Medicaid entities (FYI: it already exists, but no one uses it)

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

Assistance (one-on-one, classes, over-the-phone, web-based) on using parts of the SDAC; post TREO's SDAC webinar
Education, consultation on encryption, transmission, and storage of PHI

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

Sharing of real-time ADT data
Need to include small and single-provider practices as well

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

"No Practice Left Behind"
Many providers lack the skills to implement anything but the simplest of electronic activities. Population health management involves use of technology that many (most?) do not possess. RCCO's are well-placed to help the providers in their areas improve, as a group, toward more effective population management.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 034

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Shanna Wisdom
Location: Sterling, Logan, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Northeast Colorado Health Department
Location: Logan, Morgan, Phillips, Sedgwick, Washington, and Yuma counties, Colorado
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Health Department

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☒ 1-2 years
☐ 2-3 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
We are involved with the ACC program and the RCCOs through our involvement with the Healthy Communities program administered through HCPF. We have met with the RCCO in our region several times to discuss the possibility of becoming an ACC provider.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
We accept and bill Medicaid for some client based programs at our agency including Family Planning and Immunizations.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☒ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

Using a regional approach to see what is going to work best for each region.

2) What is not working well in the ACC Program?

It is confusing for both clients and providers. Most components of the ACC Program are unknown and not well understood. The RCCOs are divided by region, but the regions are too large and not able to cover the entire region. Instead, it seems that wherever the RCCOs main office is located is the community that benefits most.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

N/A

4) What is not working well in the BHO system?

N/A

5) What is working well with RCCO and BHO collaboration right now?

N/A

6) What is not working well with RCCO and BHO collaboration right now?

N/A

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

N/A

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed: N/A

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

I think it will be difficult in rural communities to fully integrate physical and behavioral health care into one clinical setting. In many communities there are only a handful of healthcare providers and few behavioral health providers.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

Ensuring that clients understand benefits and are able to access services to meet their needs.

b. How should RCCOs prioritize who receives care coordination first?

High Medicaid utilizers, individuals with chronic illness, and other special needs populations.

c. How should RCCOs identify clients and families who need care coordination?

Collaborate with HCPF to identify high utilizers/high needs individuals. Work with other care coordination programs to ensure that care coordination services are not being duplicated. Programs could include Healthcare Program for Children with Special Needs, Healthy Communities, Nurse Family Partnership, and Safecare.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

There should be a database to track care coordination that is occurring anywhere (other care coordination programs and at the medical provider) including what care coordination is done at the RCCO level. Communication between the programs is necessary.

12) What services should be coordinated and are there services that should not be a part of care coordination?

Need to make sure that care coordination services are not being duplicated. May vary depending on area or region, as not all services are available in every region. There should be a standard to care coordination (applying for benefits, understanding what is covered, assistance with billing issues, assistance finding providers, assistance getting DME and other services, chronic disease management and prevention, etc.) and need to collaborate with other programs who are covering these programs. There are numerous programs that offer care coordination, but there is always eligibility criteria that leave gaps in services for some individuals. The RCCO and ACA could fill these gaps in service by providing care coordination to those individuals who are not eligible for other programs.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

Insurance status, income, disability status, previous/current health and mental health conditions, and area of residence.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

Healthcare Program for Children with Special Needs, Connect for Health Colorado, Department of Human Services, Healthy Communities, Patient Navigators at Medical Provider Offices, and Nurse Family Partnership.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

There are several care coordination programs and most have a specific priority area or specialty. Most of the programs have eligibility criteria that individuals must meet before receiving services. Due to these eligibility criteria, many individuals do not qualify.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

Communication and collaboration among all care coordination programs. There should be a standard of care coordination that is available to everyone. Need to collaborate to find out what programs are already offering these services and find out where any gaps are. The ACC and RCCOs can fill the gaps in services and be the connection between the clients and other services they need.

d. What are the gaps in care coordination across the continuum of care?

Each care coordination program has different services they provide. Most programs focus on children and pregnant women. There are more gaps in services for adults, especially adults with disabilities or chronic illness.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	**Should the RCCO have a role?** Yes	No	**Should the RCCOs coordinate with community supports and services?** Yes	**Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?**
Abuse, neglect, and trauma	☐	☒	☒	Connecting patients with the resource they need, but not actually providing the service.
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	

Daycare / childcare	☐	☒	☐	Connecting patients with the resource they need, but not actually providing the service.
Economic stability & employment	☐	☒	☒	Connect with local resources including Workforce centers
Education	☐	☒	☒	Connect with local resources including alternative schools and GED programs
Environment	☐	☒	☒	Coordinate with local resources including local health environmental health and fill gaps they do not cover
Food access / nutrition	☐	☒	☒	Coordinate with
Health literacy	☒	☐	☒	Ensure clients understand what is necessary
Housing	☐	☒	☒	Coordinate with local resources including subsidized properties
Language or translation services	☒	☒	☐	
Literacy	☐	☒	☐	
Transportation	☒	☐	☐	Transportation in rural communities is often a barrier to receiving services, so coordinating and assisting with that aspect is important
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	**Coordinate care?** Yes	No	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☒	☐	In-depth chronic disease counseling, management, and prevention. Physical health checks including blood work and blood pressure.
Certified Addiction Councilors	☒	☐	Provide counseling for individuals with substance use disorders including all illegal drugs, marijuana, cigarettes, and alcohol, etc.

Certified Nurse Midwives	☒	☐	Provide information about importance of prenatal care, birth, etc.
Community Health Workers	☒	☐	Fill in the gaps where other services are not offered. Refer to other services. Be the connection between the system and the client.
Generalists (BA/BS/MA/MS)	☒	☐	Fill in the gaps where other services are not offered. Refer to other services. Be the connection between the system and the client.
Health Coaches	☒	☐	Fill in the gaps where other services are not offered. Refer to other services. Be the connection between the system and the client.
Licensed Clinical Social Workers	☒	☐	Provide counseling in a variety of areas.
Licensed Marriage and Family Therapist	☒	☐	Provide counseling in a variety of areas.
Licensed Mental Health Counselors	☒	☐	Provide counseling in a variety of areas.
Licensed Professional Counselor	☒	☐	Provide counseling in a variety of areas.
Masters of Public Health	☒	☐	Fill in the gaps where other services are not offered. Refer to other services. Be the connection between the system and the client.
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	Provide in-depth information on chronic disease prevention
Nurse Practitioners	☒	☐	Provide in-depth information on chronic disease prevention
Patient Navigators	☒	☐	Fill in the gaps and connect clients/patients to services in their communities. Be a liaison between the client and the healthcare system.
Peer Advocates	☒	☐	Connect patients with local resources and assistance navigating systems they, themselves, have been part of.
Promotoras	☒	☐	Fill in the gaps and connect clients/patients to services in their communities. Be a liaison between the client and the healthcare system.
Psychiatrists	☒	☐	Routine care and referrals to other community resources if needed.
Psychologists	☒	☐	Routine care and referrals to other community resources if needed.

Registered Nurses	☒	☐	Routine care and referrals to other community resources if needed. In-depth knowledge about chronic disease prevention.
Social Workers	☒	☐	Routine care and referrals to other community resources if needed.
Wraparound facilitators	☒	☐	Fill in the gaps and connect clients/patients to services in their communities. Be a liaison between the client and the healthcare system.
Other	Please type your response here.		

17) **Care coordination requirements for specific populations**. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☒	
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☒	☐	Need to know what community resources there are to assist.
Children involved in the foster care system	☒	☐	Need case manager/community worker to help navigate the child and involved families through the complex system to make sure every need is being addressed. Must be knowledgeable about many systems.
Children with a chronic illness	☒	☐	Need to know what community resources are there to assist and how to navigate through those systems.
Children with a serious emotional disturbance	☒	☐	Schools, social workers/therapists, etc. need to be involved and work together for treatment plan.
Children with medical complexity	☒	☐	Need to know what community resources are there to assist and how to navigate through those systems.
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	Need to know what community resources are there to assist and how to navigate through the system.
Transition-age adolescents	☐	☒	
Parents and families	☐	☒	
Pregnant women	☒	☐	Need to know what community resources are there to assist and how to navigate through the system.
Adults	☐	☒	

Adults who are healthy, but in socially-complex situations	☒	☐	Need to know what community resources there are to assist.
Adults with a chronic illness	☒	☐	Need to know what community resources are there to assist and how to navigate through those systems.
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	Need to know what community resources are available there are to assist.
Clients involved in the criminal justice system	☐	☒	
Clients with a disability	☒	☐	Need to know what community resources are available
Clients in a nursing facility	☐	☒	
Elderly clients	☒	☐	Need to know what community resources are available and how to navigate the systems they are part of.
Frail elderly clients	☒	☐	Need to know what community resources are available and how to navigate the systems they are part of.
Clients in palliative care	☒	☒	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

I envision them having a good understanding of the systems, to make sure there is a continuity of care for the children that move within the foster care system. Ensuring that the children remain on Medicaid and are getting the appropriate preventive care while in foster care. Referring to the appropriate behavioral health resources and other community resources if necessary.

19) How should care coordination be evaluated? How should its outcomes be measured?

Medicaid billing information (preventive services, high cost procedures). Number of interactions and contacts with clients. Agency collaboration and processes.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

N/A

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

N/A

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

Yes. From my opinion, it seems that care coordination is about quantity instead of quality. There is a significant learning curve associated with being an effective care coordinator and sufficient time and attention needs to be paid to the coordination and training of other staff members. All of this in addition to having enough staff capacity to assist clients through the various systems they may be involved with.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☒
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

Medicaid billing (preventive and high cost services), community resources (oral health screenings/referrals, vision screenings, developmental screenings, social/emotional screenings). There are local resources that many families take advantage of and the current evaluation only takes into account the services that can be billed to Medicaid. It seems like we push certain services depending on what measures are being evaluated without considering or asking what the clients may actually need.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

N/A

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Care coordination requirements either to be met by the RCCO or in collaboration with local community resources. Data sharing between the RCCO and community organizations who are also doing care coordination. Contracting with providers to be part of the ACC, but also to accept Medicaid in general. In our region there is a lack of healthcare, vision, and dental providers who accept adult Medicaid or greatly limit the number of patients they see.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Office locations/capability in every city to be served and current relationships with community partners. Adequate staff capacity.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

Some RCCOs probably have more capacity to reach clients than others. I think whoever is logistically able to provide care coordination for the clients should be able to.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. I think the regions are too large. There is not enough staff capacity at some of the RCCOs to realistically reach the clients and area they are supposed to serve. Rural versus urban needs to be considered.

28) Should the BHO region maps change? Why or why not? If so, how?

N/A

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

N/A

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

N/A

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

N/A

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

I do not think there should be multiple RCCOs per region. I do not think the RCCOs should compete for clients and providers.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

N/A

34) What role should RCCOs play in attributing clients to their respective PCMPs?

N/A

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

Data sharing between programs that are administered through the Colorado Department of Public Health and Environment to ensure we are working towards the same goals without duplicating services or programs.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

Data sharing between programs. Care coordination at the local Department of Human Services offices. Medicaid billing for services.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

Care coordination at the Connect for Health Assistance Sites.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

N/A

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

Being available at the local level to build relationships. Focus groups and other ways of gathering qualitative information for the area.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

Being available at the local level to build relationships. Hosts meetings, understand how everyone can collaborate, provide necessary resources and training.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

Being available locally to build a strong relationship in the respective community.

42) How can the Department structure stakeholder engagement for the ACC as a whole?

Brief online surveys, focus groups, Q&A sessions. Many people do not understand the ACC, or only understand a part of it and do not understand how it all works together. The Department needs to gather information from the correct sources and how individuals understand the ACC on different levels. Every level needs to be included to get a realistic idea of what the best practices should be. Clients, community health workers, billing staff, nurses, physicians, front office staff, DHS eligibility technicians, mental health professionals, CEOs, managers, etc. all need to be included.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

In our region, vision, dental, specialists, and mental health providers are lacking for all ages, and all resources are lacking for adults including healthcare providers.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

Adults and adults/children with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

Ensuring that clients are eligible for services and assist them with billing issues associated with hospital services. Track and case manage clients that have utilized the emergency department.

b. What role should pharmacies play in the next iteration of the ACC Program?

Ensuring that clients are eligible for prescriptions. Limit clients from having to pay out of pocket due to errors in the system. Should be able to assist clients with pharmacy billing issues.

c. What role should specialists play in the next iteration of the ACC Program?

Ensuring that clients are eligible for services. Assist with billing issues related to services provided. Collaborate with local organizations in communities that do not have adequate specialists to provide services to clients in those counties.

d. What role should home health play in the next iteration of the ACC Program?

Ensuring that clients are eligible for services. Assist with navigating the home health systems while providing the care that the client needs. Collaborate with pharmacies, physicians, hospitals on behalf of the clients.

e. What role should hospice care play in the next iteration of the ACC Program?

Ensure that clients are eligible for services. Assist with navigating the hospice care system.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

Provide outreach and awareness to other local organizations who may need to refer clients to Single Entry Points. In our region, there is confusion as to what organizations are the Single Entry Points and what they are capable of assisting clients with.

g. What role should counties play in the next iteration of the ACC Program?

Counties should assist with eligibility for income based programs and provide referrals to other agencies.

h. What role should local public health agencies play in the next iteration of the ACC Program?

Local public health agencies should be a liaison between clients, healthcare, mental health, DHS, and other community partners to best assist the client. They should know what organizations provide the specific services to refer clients to. Important to build strong relationships with all of the partner agencies to best serve clients.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

Community partners are important to the ACC Program, depending on what services they provide. Many community partners can refer clients to appropriate services, emphasize the importance of preventive care, and be in direct contact with clients. It is important to include them for the areas that they specialize in so that care coordination efforts are not duplicated in each community.

45) How can RCCOs help to support clients and families in making and keeping appointments?

Reminder phone calls, assistance with transportation, education on the importance of preventive care and Medicaid reimbursement and the importance of showing up for appointments

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

Community Health Workers or Patient Navigators should be required as part of the next RFP. Provider offices and organizations operate differently, but the resources available to clients in their respective communities are the same. There should be a standard Community Health Worker training for all ACC Community Health Workers/Patient Navigators with a focus on the specific community they will serve. The training could be broken down by county or small regions with similar resources. It is very important for the health workers to be familiar with the communities they serve to be able to refer clients to a wide variety of services and conduct follow-up.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☒

On staff (salary) at Primary Care Medical Provider Clinic	☒
On staff (salary) at RCCO	☒
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

Assist dental providers to become Medicaid providers. In our region, the Medicaid reimbursement rate and the rate of no shows is detrimental to our independent dental providers. They need assistance in navigating the system of becoming a Medicaid provider.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

Cultural competence means that you are able to understand and accept diversity. Ethnic, racial, monetary, class, etc. diversity are all examples.

b. What RCCO requirements would ensure cultural competency?

Providing/funding training opportunities for community partners and healthcare and mental health providers. It is important the community as a whole be culturally competent.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

They need to understand poverty and the affect is has on individuals. They need to understand and accept the different cultures and backgrounds that clients come from. They need to be open-minded and respectful. Bilingual if possible or have the resources to be able to translate.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Training, continuing education requirements

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

N/A

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Collaborate with emergency departments to share data about high utilizers to see if something can be done to intervene on the individual level. Education about preventive care and the proper way to utilize the emergency department.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☒	☐	☐	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☒	☐	☐	☐
Provide registries	☒	☐	☐	☐
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☒	☐	☒	☒
Offer educational materials about specific conditions	☒	☐	☒	☒
Supply behavioral health surveys	☒	☐	☒	☐
Supply other self-screening tools	☒	☐	☒	☐
Administer behavioral health surveys	☒	☐	☐	☐
Administer other self-screening tools	☒	☐	☐	☐
Prepare client action plans	☒	☐	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☒	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☒	☐	☐	☐
Provide standing pharmacy order templates	☒	☐	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☐
Provide directory of other resources	☒	☐	☐	☐
Provide materials regarding Nurse Advice Line	☒	☐	☒	☒
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

Evidence-based chronic disease management assessments, educational information, etc.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

N/A

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

Client behaviors and outcomes

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

No, I do not think that disease registries should be used to manage populations.

58) Please share any other advice or suggestions about provider support in the ACC.

N/A

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

N/A

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

N/A

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

N/A

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited 5ervice Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

N/A

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

N/A

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

N/A

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

N/A

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

Yearly public health led community-wide assessment

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

N/A

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

No, RCCO's should not be paid on the same KPIs across the state. KPIs can be standard across the state, but payment should not be based solely on those indicators.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Reimbursement could be a mixture of comparison to national standards and based on improvement.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

Many significant health changes cannot be measured on a monthly or regular basis and would only show change if measured less often. It is important to use claims data to get an overview of trends, but it is also important to look at more qualitative measures specific to the clinic or region.

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

N/A

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

N/A

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☒	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the 5DAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☒	☐
Care management tool	☐	☐	☐	☒	☐
Care transitions alerts	☐	☐	☐	☒	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☐	☒	☐
Health risk assessment software	☐	☐	☐	☒	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☒	☐
Patient education wellness tools	☐	☐	☐	☒	☐
Provider/case manager directory	☐	☐	☐	☒	☐
5hared decision-making tools	☐	☐	☐	☒	☐
Telemedicine	☐	☒	☒	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

The cost associated with implementing the system itself and the time to train staff on a new system.

81) How can Health Information Technology support Behavioral Health Integration?

N/A

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

N/A

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

N/A

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

N/A

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

It would need to be broken down by county/city, specialty (general, ob-gyn, etc.), name of practice, address, phone number, and whether they are accepting new clients and adults. It doesn't seem as useful to break down the individual physicians, but rather to have the practice name. Individual physicians at a given practice change very frequently so it is hard to keep up to date. In our region, there may be 50 providers, but in only 10 locations.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

N/A

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

N/A

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

N/A

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

N/A

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

N/A

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 035

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Ronne Hines
Location: Denver Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Department of Regulatory Agencies, Division of Professions and Occupations
Location: Denver, Colorado
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): State Agency

Are you currently involved in the ACC program?

☐ Yes
☒ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

As a sister state agency, we keep abreast of programs that affect any segment of Colorado's regulated healthcare workforce.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☒ N/A

Please feel welcome to describe why or why not using the space below.

☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

2) What is not working well in the ACC Program?

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Outreach. Integrated care has been a topic of discussion for many years, but confusion remains. Providers working in traditional practice settings have many questions about how the new systems can work. From a regulatory perspective, they need to know what legal and regulatory issues may limit or expand opportunities to work in more integrated settings. Care providers need to know what is acceptable and what is not, how reimbursement will work and how they need to integrate compliance with the various professions working within the integrated model. As an example, mental health licensees must have a mandatory disclosure form on file for clients they are treating. How does that fit into integrated practice? Also, how do federal requirements for psychotherapy record protection and protection of drug and alcohol treatment records play into the integrated healthcare model? Similar questions exist for doctors, physician assistants and advance practice nurses who provide primary care. These professions are typically unfamiliar with the different requirements related to mental health such as record retention and disclosure forms. Increasing outreach and educational initiatives that explain what integrated care really means and looks like is essential. This outreach should not just be for those currently providing treatment in an integrated model. Many may be interested and not know where to find the information. Professional associations such as the National Association of Social Workers - Colorado Chapter and the Colorado Psychological Association may be able to provide further information in this area.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☒	☐	As outlined in Q7
Professional / cultural divisions	☒	☐	Many primary care providers are unfamiliar with the integrated approach
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

b. How should RCCOs prioritize who receives care coordination first?

c. How should RCCOs identify clients and families who need care coordination?

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	
Health literacy	☐	☐	☐	
Housing	☐	☐	☐	
Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	
Transportation	☐	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	Coordinate care? No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	Yes, within their scope of practice (SOP). APRNs are direct care providers and may not be willing to lead care coordination.
Certified Addiction Councilors	☐	☒	May be too specialized for care coordination.
Certified Nurse Midwives	☒	☐	Yes, within their scope of practice (SOP). CNMs are direct care providers and may not be willing to lead care coordination.
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☒	These are unlicensed.
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☒	☐	
Licensed Mental Health Counselors	☐	☐	Not sure what professionals are included in this category. This is not a recognized profession in Colorado.
Licensed Professional Counselor	☒	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	Yes. Doctors are direct care providers and may not be willing to lead care coordination.
Nurse Practitioners	☒	☐	Yes, within their scope of practice (SOP). NPs are direct care providers and may not be willing to lead care coordination.
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☒	☐	

Registered Nurses	☒	☐	Yes, within their scope of practice (SOP). APRNs are direct care providers and may not be willing to lead care coordination.
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

    a. What is the PMPM cost for providing care coordination services?

    b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

    a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

The Division of Professions and Occupations (DPO) at the Department of Regulatory Agencies is the sole regulatory body for 29 different healthcare professions. As the ACC continues to grow and new ideas spawn, the ACC must communicate with DPO to ensure regulatory barriers do not inhibit Medicaid client's access to integrated care. However, while DORA wants Medicaid clients to have good access to the services they need, it cannot happen at the expense of patient safety. Healthcare providers should be able to work to the full extent of their scope of practice as the healthcare system continues to move through an era of great transformation. As regulators, the Division must ensure that healthcare providers can thrive in their communities with minimal regulatory burden and an appropriate amount of consumer protections in place.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

The ACC model touches many parts of an individual Medicaid client's community. Therefore, the Department needs to place the Medicaid client in the center and engage with any system or organization that may touch the client's overall health or healthcare services. Once the systems and organizations are identified, the Department can begin to see how an entire community can work together to better the health of its citizenry which includes Medicaid clients. This will involve private businesses, public programs, public-private partnerships, non-profits and philanthropic entities that may have a willingness to help, but lack an understanding of how to engage. Bridging that gap will be key. As a stakeholder, DORA wants to know about the ACC's expectations for providers and how those expectations intersect with various scopes of practice and other variables within the regulatory structures. This is vital to ensure providers and consumers interact in a safe, consumer centered system.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

Pharmacies should clearly communicate what drugs they have available and which drugs have been approved for auto-substitution by a hospital's Pharmacy & Therapeutics Committee. In the case of hospital pharmacies, the auto-substitution can be a key factor in cost savings efforts. At the same time, pharmacies need to understand which of the approved drugs will be covered under Medicaid. This will help avoid patient confusion after patient discharge, when billing occurs for drugs used while at the hospital. This also will help avoid situations where patients obtain their prescriptions in a retail pharmacy setting and discover that certain prescriptions are not covered by Medicaid. In these circumstances, consumers are sometimes left with a heavy cost burden. In addition, pharmacists should work with Medicaid clients and their prescribing practitioners to avoid therapeutic duplication. They can provide the same level of care without unnecessary or duplicative costs associated with therapeutic duplication.

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47) **Community Health Worker reimbursement**. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices**. Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type**. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☐
Care management tool	☐	☐	☐	☐	☐
Care transitions alerts	☐	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☐
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Studies have identified a number of barriers to providers implementing and increasing their use of HIT, including situational barriers (including time and financial concerns), cognitive and or physical barriers (including physical disabilities and insufficient computer skills), liability barriers (including confidentiality concerns), and knowledge and attitudinal barriers.

81) How can Health Information Technology support Behavioral Health Integration?

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 036

Accepted by: KJDW

Notes: Standard cover sheet added; converted to Word

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for information:

Please provide your name and location:

Name: Gall L. Bleibtrey

Location:Guardian Angels Hith Ctr

If you are a member of (or affiliated with) an association, business, or other simiiar entity, please provide the name and location of that organization:

Name of organization:Guardian Angels Hlth Ctr

Location:Aurora, CO

☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that appiy:

☐ Client
☐ Client's famiiy member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty:
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medicai society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected officiai
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Attend meetings, have representatives come to our practice to discuss policy and procedures for how to better assist patients and provide families with resources they are in need of.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

We are a certified medical home, our practice is approximately 82% Colorado Medicaid based.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☒ 3-4 years
☐ Since before the program was implemented.

☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.
- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.
- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.
- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:
    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.

- o if the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.
- o So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
- o Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
- o There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend

- if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing SDAC data is just one way to understand the activities within a medical home. SDAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:

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a. Assistance with finding a behavioral health provider for patients
b. Telephone consultation by a child psychiatrist to primary care providers
We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. in order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Core Coordinotion

Question 12) What needs for children/fomilies should be coordinoted in medicol homes ond ore there services thot should not be o port of core coordinotion by the pediotric ond fomily medicol home

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Our medical home relates to multiple RCCOs and we want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we could receive a pmpm from all of them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where should care coordination be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill? The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County
- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high

performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPis need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TiME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

- Since children are the majority and give the best chance of truly improving health and wellness, KPis need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

<u>There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully.</u> Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. it would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TiME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CiVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medicai homes have the capabiiity and infrastructure to adapt to payment tied to vaiue. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure eiements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee shouid meet at a time when providers and practice managers can actualiy attend. Monday afternoons is probably the worst time to actualiy enabie providers or practice managers to attend. Once you seiect an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and heaith outcomes?

- Many medicai homes have the abiiity to coliect from their EHR and their claims database REAL-TiME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CiVHC, and RCCOs oniy have Medicaid claims data, which is far too deiayed to be usefui for medical homes to use to do rapid cycie quaiity improvement to improve performance in a timeiy manner. Therefore, HCPF and RCCOs wiii have to use data self-reported from medical homes to obtain real-time, useabie data. This requires that HCPF and RCCOs work closeiy with representative practice managers and provider from medical homes to deveiop a vetting process that wiii enable HCPF and RCCOs to trust medicai home self-reported real-time data.

- The measures for chiidren can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the heip of Jim Todd. Appropriate chiid health measures could be seiected from the foiiowing measures :
  - Weii chiid visits appropriate for age
  - Deveiopmental screening by three years of age
  - Teen depression screening
  - Compiete immunization status by age two
  - Post-partum depression screening rate for mothers of newborns by age 4 months
  - Appropriate antibiotic use in URI and strep pharyngitis

- Medicai homes couid aiso be measured on:
  - Patient (or famiiy) satisfaction ratings
  - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. if you are going to have KPIs, then you need to track not only the number of times a screening was done, but aiso track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the iine. Other ACO programs have shown that savings on children are difficuit to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the tabie below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more wiil diiute the effect. What we reaily want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 037

Accepted by: KJDW

Notes: Standard cover sheet added; converted to Word

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

Request for Information

State of Colorado
Department of Health Care Policy and Financing

Response to RFI UHAA 2015000017
Accountable Care Collaborative Request for Information (RFI)

November 24, 2014

Contact: Angela Moore, Client Alignment Executive
863.701.4707
Amoore1@ntst.com

Transmittal Letter

November 24, 2014

Mr. Kevin Dunlevy-Wilson
Department of Health Care Policy and Financing
Accountable Care Collaborative Strategy Unit
1570 Grant Street
Denver, CO 80203

Dear Mr. Dunlevy-Wilson:

Please accept Netsmart Technologies, Inc.'s response to Colorado Department of Health Care Policy and Financing's RFI UHAA 2015000017. This response is valid for ninety (90) days from the submission date of November 24, 2014.

Thank you for including Netsmart in your RFI process. As a leader in the behavioral health and human services community, we are a vision-driven company that is passionate about the opportunity and the obligations that accompany our commitment. We emphasize partnering with our clients, using our resources for the collective good of the community, and leadership through innovation.

We look forward to demonstrating Netsmart's CareRecord solution to the Colorado Department of Health Care Policy and Financing. Please feel free to contact Angela Moore, Client Alignment Executive, with any of your questions or comments at (phone) 863-701-4707 or (email) amoore1@ntst.com.

Sincerely,

(Signature via Email Delivery)

Thomas Herzog, Chief Operating Officer Netsmart
Technologies, Inc.
4950 College Blvd.
Overland Park, KS 66211
800.842.1973 (ph) • 913.696.3492 (fx) • therzog@ntst.com

Contents

Executive Summary

Our Partnership Goals

At the heart of Netsmart's partnership with the State of Colorado is the goal of improving the quality of life for all Colorado consumers. We intend to accomplish this by growing our long term relationship with the State of Colorado's Department of Health Care Policy and Finance. Together, Netsmart and the Health Care Policy and Finance Division can achieve coordinated and collaborative care to drive down costs, improve outcomes, and optimize technology innovations.

Please find through our responses and attachments, our dedication to facilitating coordinated care across providers.

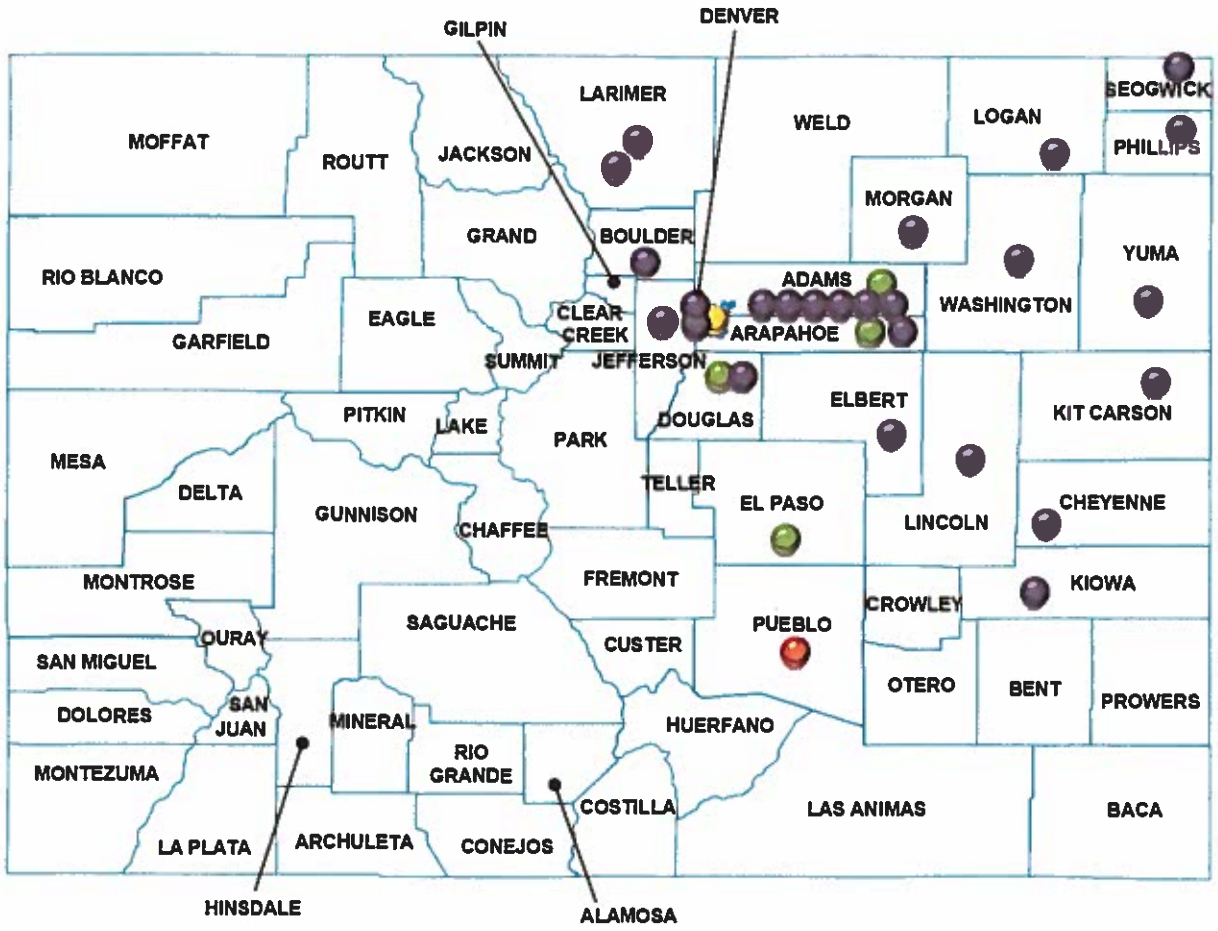
Netsmart has a long term relationship with the State of Colorado. In addition to past work for CDHS at Fort Logan and Pueblo, Netsmart has served the Colorado community for more than 30 years with Centers such as:

- The Mental Health Center of Denver
- The Jefferson Center
- Community Reach Center
- North Range
- Mental Health Partners of Boulder
- Arapahoe Mental Health
- Tri-County Public Health Department
- El Paso Public Health Department

Over the years, several of these Centers have elected to grow their investment and leverage the HHS specific innovation that only Netsmart brings to the market. The growth of our innovative offerings have been the driving force in proving that we listen to the needs of our communities and follow through with services, such as CareManager, that directly improve efficiency.

The Community Crisis Connection (CCC), recently was awarded a $20m contract to provide Crisis Services across six service providers, many of which are current Netsmart clients. They will leverage data analytics based on CCAR and other community-based measures. This project sets the stage for a broader Care Management foundation for the people in across the state that experience a Mental Health crisis. Core to this new program, CRC will leverage Netsmart solutions to support delivery of 24 x 7 one-stop crisis services across the consortium of providers.

Netsmart Footprint in Colorado



Public Health Behavioral/Mental Health State Inpatient Psych State Inpatient Forensic Psych

Why Netsmart?

CareManager™

CareManager Connects and Coordinates Data for Better Treatment of Consumer Populations

With increasing pressure to coordinate care across the full spectrum of providers and better treat consumer populations, health and human services organizations need solutions that enable cross-organizational care management. Taking a step beyond the recent initiative to

simply connect provider organizations and share consumer data, the newest federal goals aim to designate responsible organizations to coordinate and manage the care of identified consumer populations. These initiatives bring sweeping changes across the healthcare industry.

Colorado's HCPF Department seeking responses to the Accountable Care Collaborative system is in line with these goals and initiatives, in adherence to the following principles:

- To operate the accountable care of Colorado consumers safely, securely and efficiently;
  □ To decrease the circumstances that lead to medication and prescribing errors;
- To increase the application of clinical information that promotes a lessening in the use of the most intrusive interventions (such as seclusion and restraint);
- To decrease the consumers' needs for extended, inpatient stays, strengthen clinical hand-offs between prior and next providers, and advance each consumer's recovery into a sustained community integration;
- To improve outcomes for recovery and resiliency of patients served; and
- To achieve the Department's Triple Aim goals of Health, "Better Health, Better Care, and Lower Cost."

Netsmart is at the forefront of healthcare reform with new solutions to enable the coordinated care management which is key to accomplishing the stated goals, reducing hospitalizations and shifting and maintaining care in community based settings with improved outcomes, resiliency and engagement of identified populations.

CareManager is platform agnostic and aligns to the way care is managed across a continuum of providers. In addition, realizing care management and coordination initiatives wouldn't take on a single model, Netsmart established a team of associates to ensure the solutions align to different models while ensuring the solution is flexible enough to accommodate future needs.

Exchange Consumer Data

CareManager facilitates coordinated care across providers. Clinicians have access to all the consumer's records for which they have appropriate access. This comprehensive view into a

consumer's health provides the clinician a much broader understanding of their situation and makes them better equipped to diagnose and make recommendations that may vastly improve a consumer's outcome.

Coordinate Care Across Providers

CareManager is able to send proactive alerts so care managers can take proactive action. Contacting consumers and helping them manage their at-home responsibilities can have a dramatic impact on their lives.

Track Clinical Quality Measures and Outcomes

As this new concept of providing accountable care takes hold, organizations will be required to track designated quality measures to demonstrate improvements in outcomes with the populations for which they're responsible. As such, there is a need for reliable methods for tracking the specific quality measures for which the organization may be held accountable. As part of the CareManager roadmap, Netsmart is planning to build in a framework for quality measures which would allow an organization to gain insight into the quality of the care they manage.

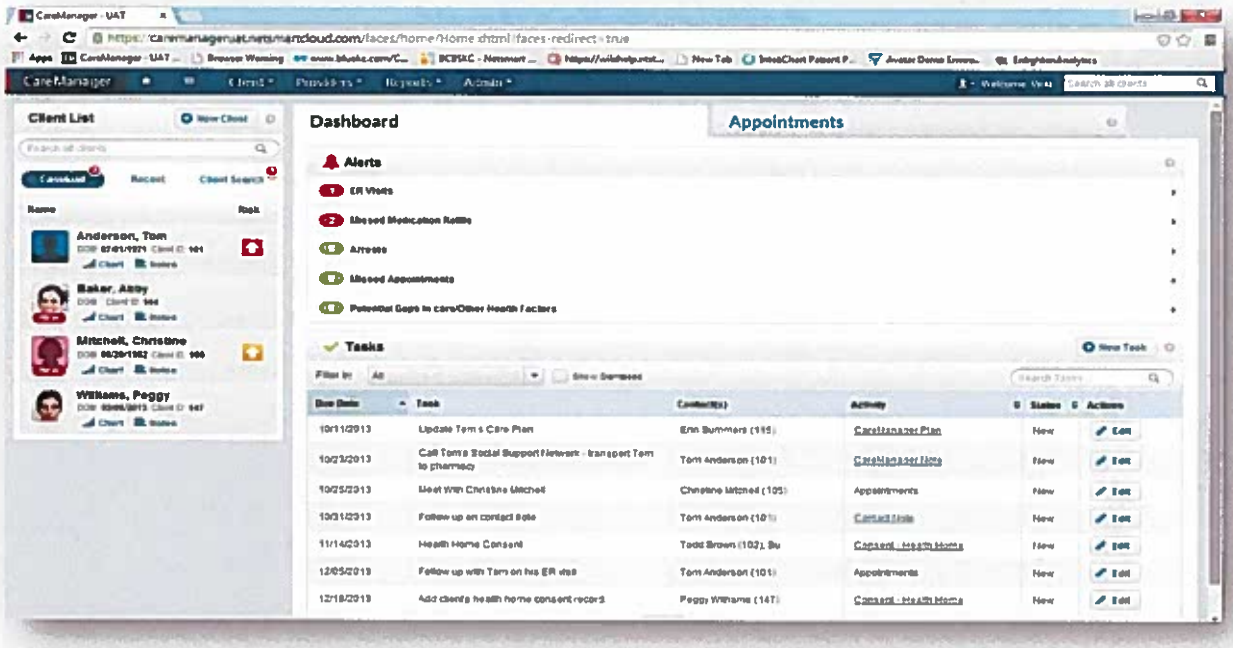
CareManager Features

Priority	Definition
Care Coordination	Manage consumer engagement, consent and assessments. The engagement and assessment process will help identify, at a high level, the consumer's needs and current challenges that need to be addressed. Connecting these business processes together, care managers can create a care plan and stratify the consumer so they can refer them to the most appropriate providers.
Population Management	Review the consumer data collected from all the providers to gather knowledge about the population. Information like percentage of high-, medium- and low-touch clients will support staffing decisions.
Referrals	Access a provider registry to locate an optimal provider. Initiate referrals from within the care planning process.
HIE Interface	Connect to HIEs/RHIOs in order to exchange items like care plans, patient demographics and treatment providers.

CareManager Screen Shots

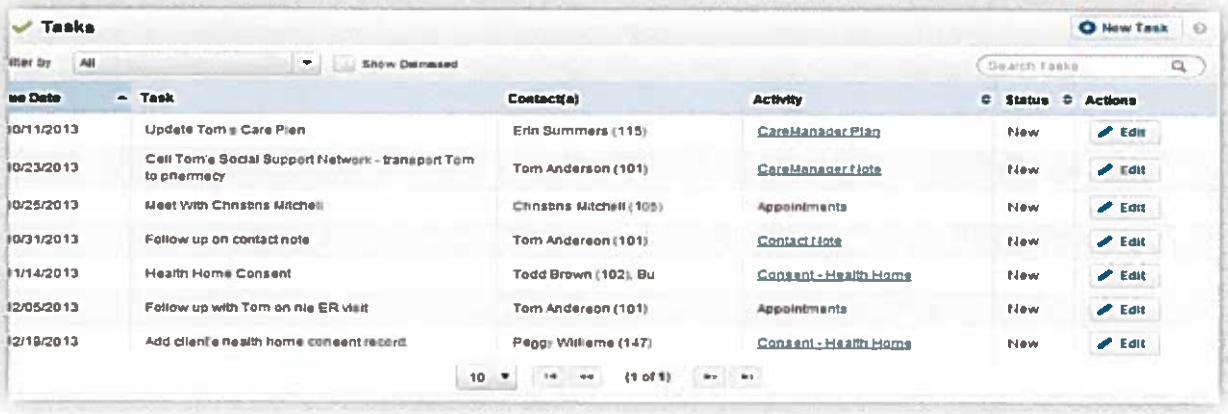
Dashboard

This home view provides the team member a quick view into their case load and activities. See alerts issued for members in their case load, tasks to be acted on, and calendar view of appointments.



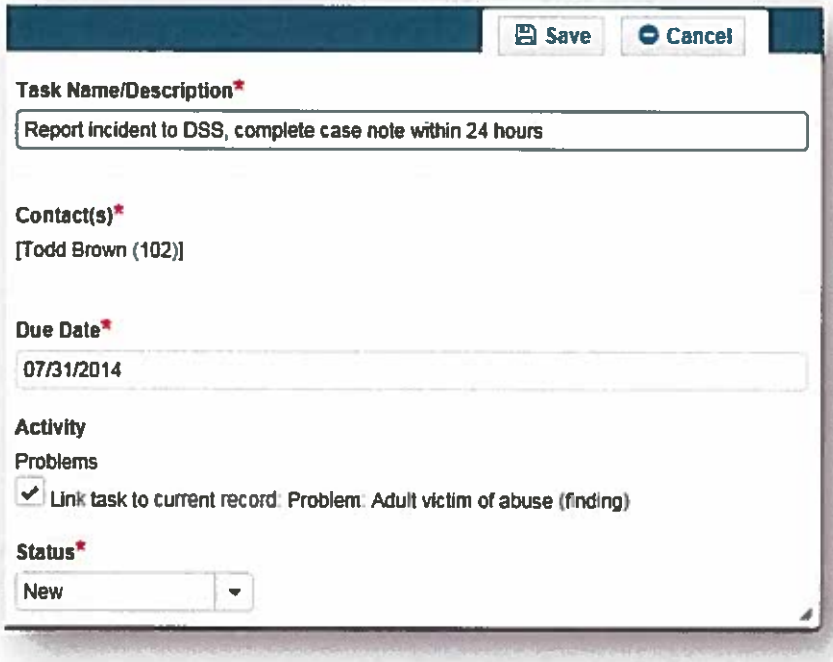
Task List

The care manager's to-do list; view tasks and access related activities, resolve tasks or create and assign new ones. Tasks are not only an effective tool to focus resources on issues requiring resolution, but it is also a powerful tool for ensuring care coordination by way of engaging team members in joint activities.



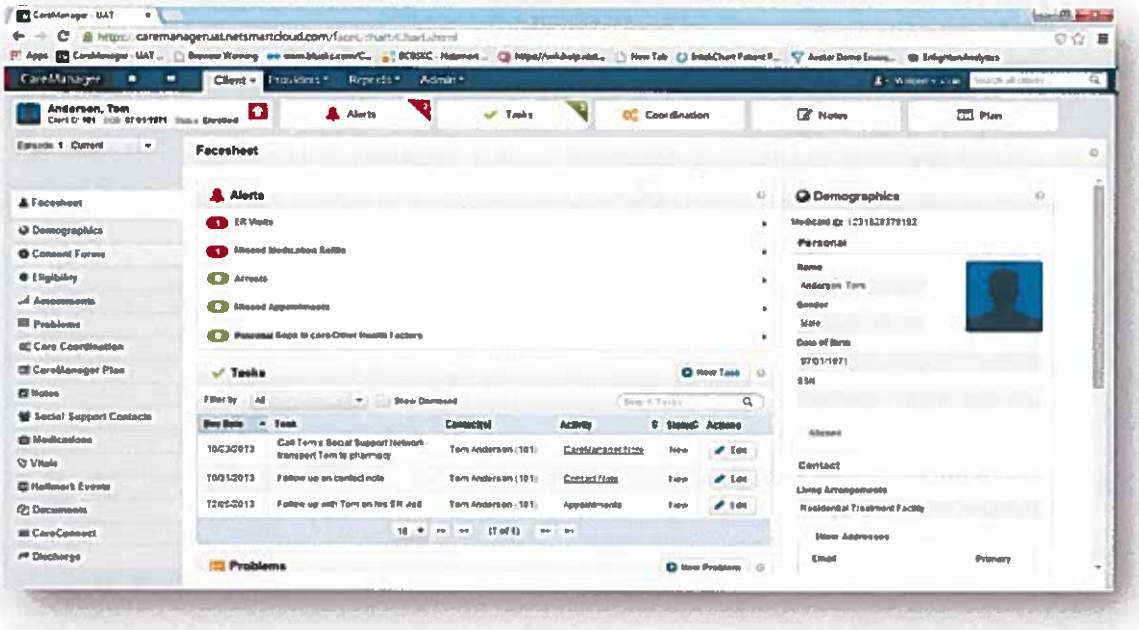
Task Detail View

Define a task, include contacts (client, team members) to be assigned the task, define a due date and link to a care plan, problem, note, assessment or any other activity in CareManager.



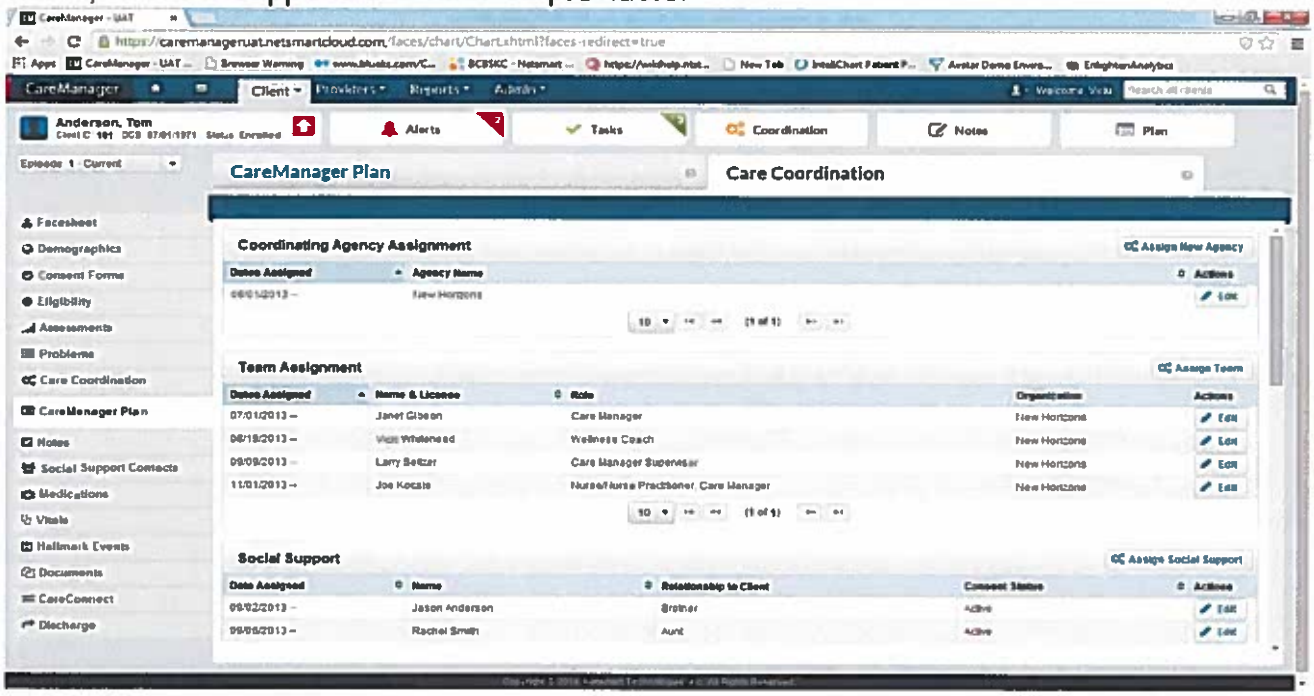
Member Facesheet - Person Centered View

Care Manager view of the full care record for the member; Alerts and tasks specific to the member, health concerns and care team, and access to all areas of the member chart all in one intuitive location.



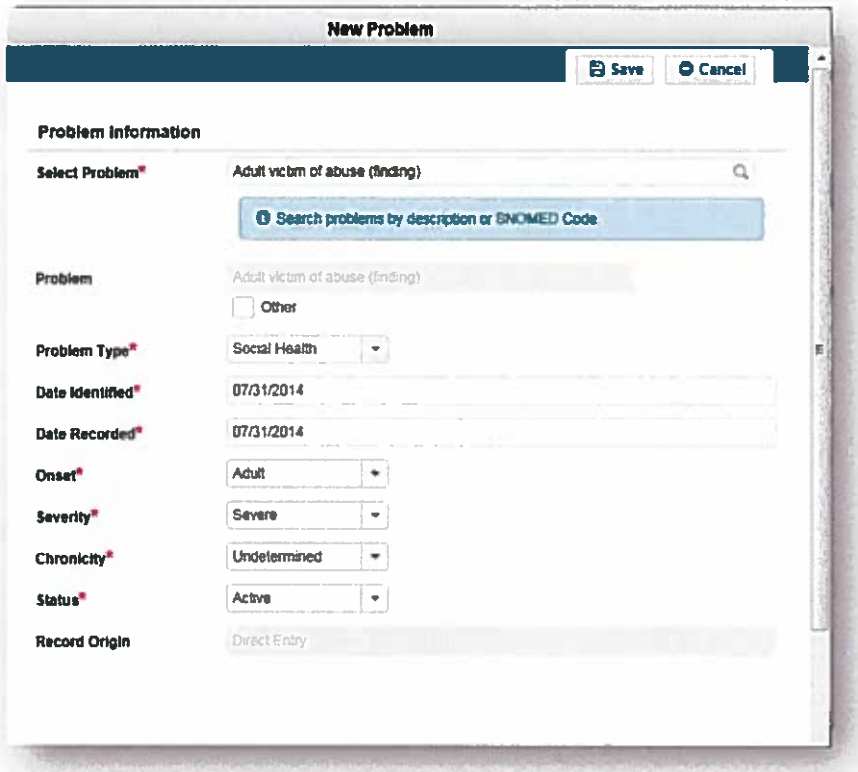
Care Coordination – Team Assignment

Assign and record team members, from care coordination agency, internal assigned care team, to social supports and referred providers.



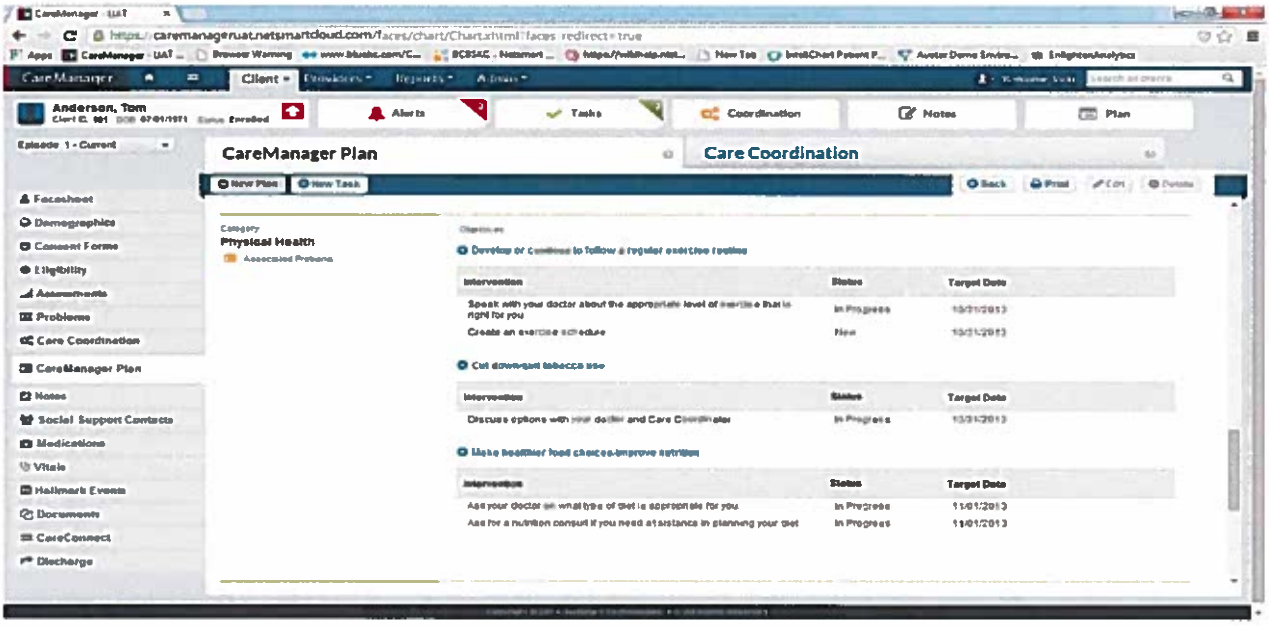
Member Care Plan – Member Problem List

Problems, or health concerns, are part of the members' health status. They can be associated with care plan interventions and provider referrals.

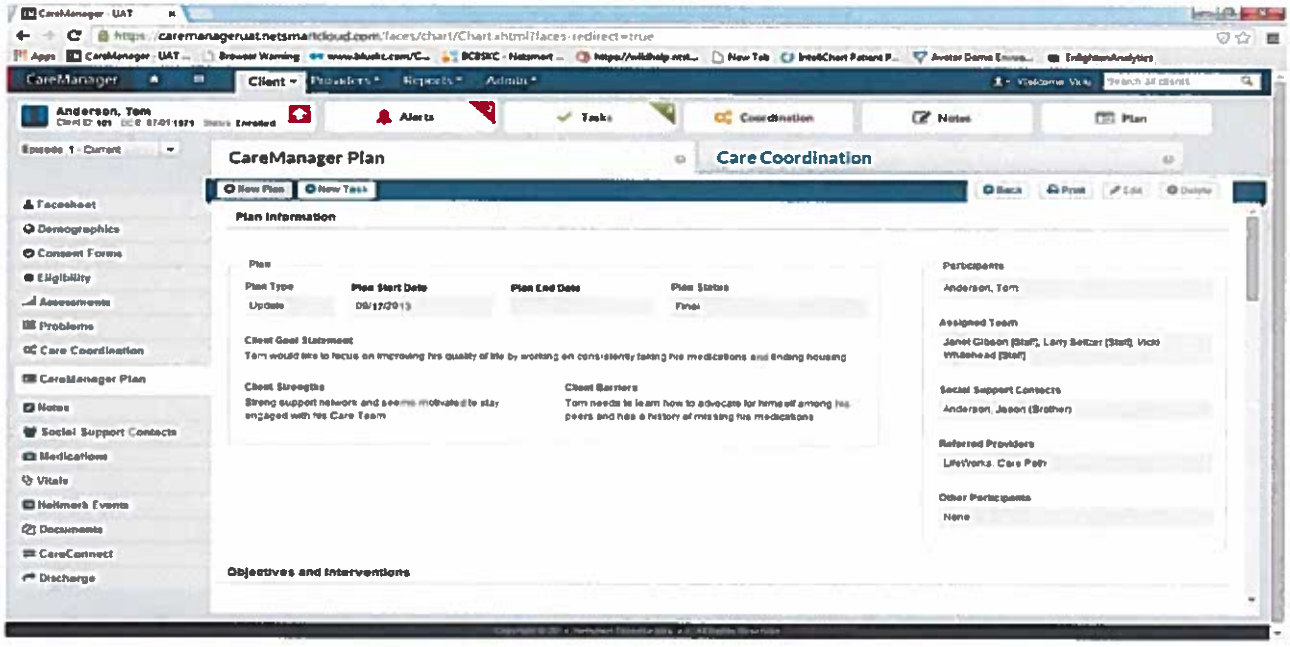


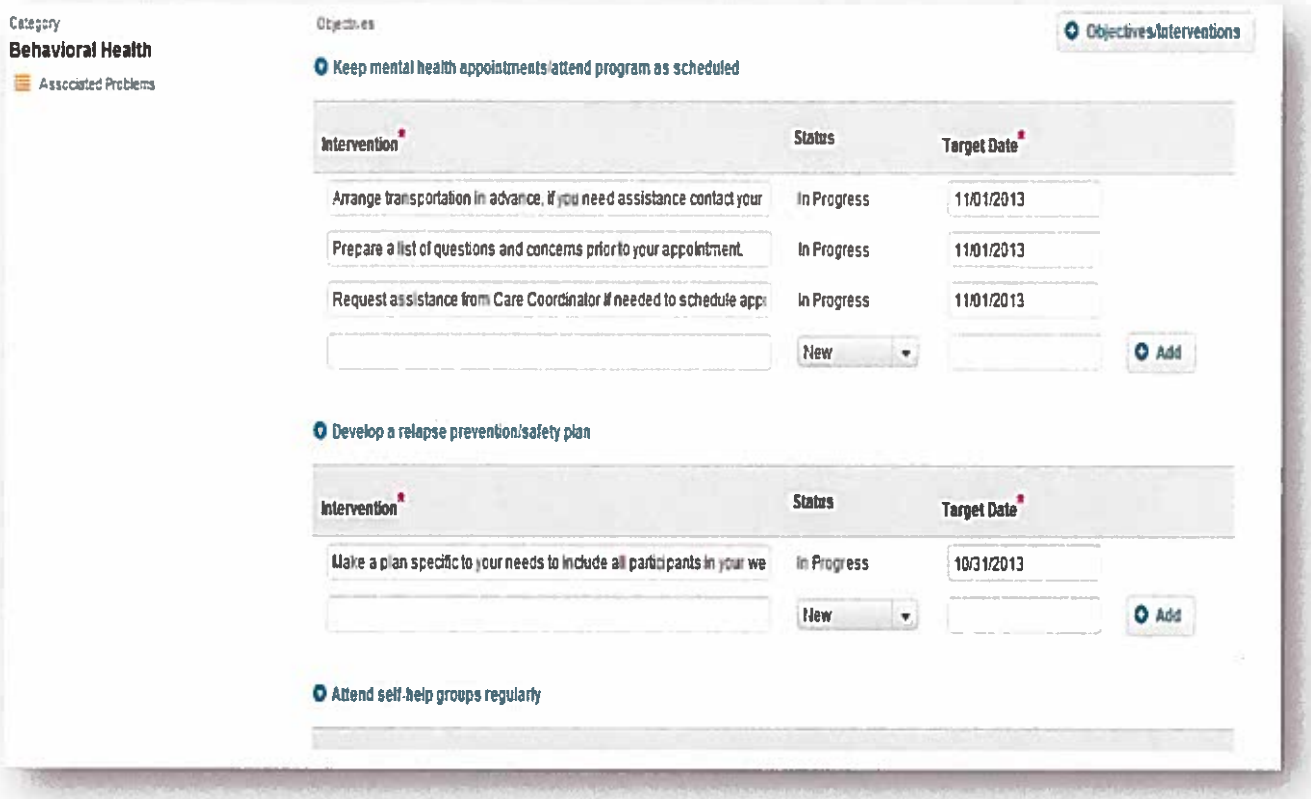
Care Plan View

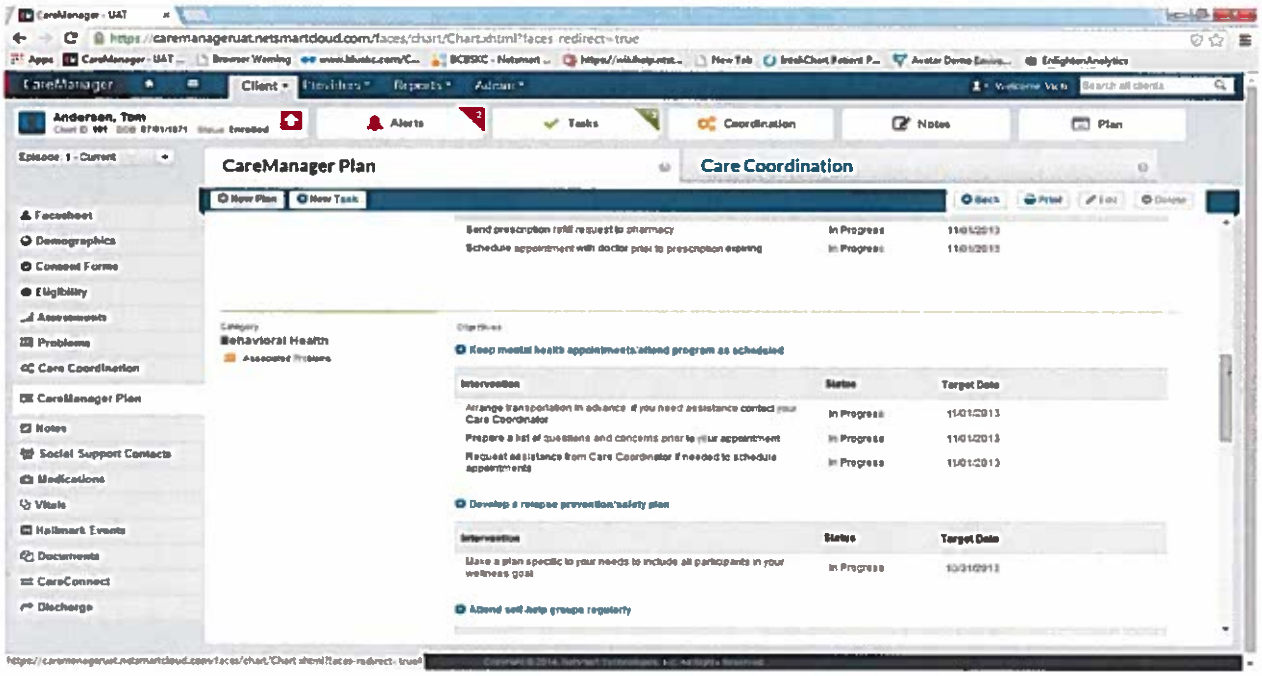
The care plan is a living document that serves as the overall work plan for the member and their care team to document issues, goals and interventions, assign to internal and external team members, supports and providers, and track outcomes and engagement.



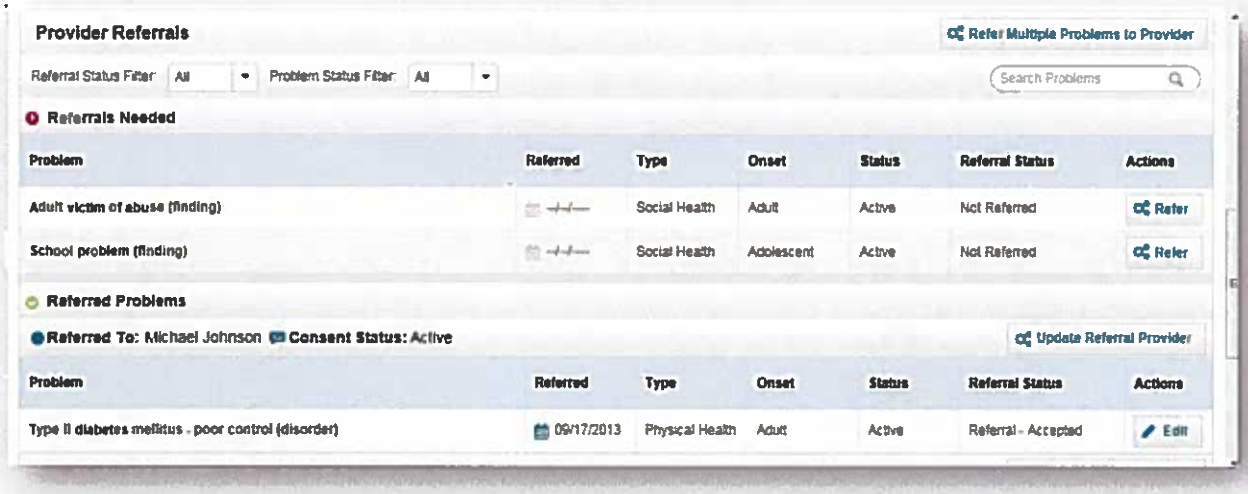
The Care Plan is categorized by Domains, associated with Problems, and lists goals and related interventions.




Category
Behavioral Health
Associated Problems
Objectives
Objectives/Interventions
Keep mental health appointments/attend program as scheduled
Intervention
Status
Target Date
Arrange transportation in advance, if you need assistance contact your
In Progress
11/01/2013
Prepare a list of questions and concerns prior to your appointment.
In Progress
11/01/2013
Request assistance from Care Coordinator if needed to schedule app
In Progress
11/01/2013
New
Add
Develop a relapse prevention/safety plan
Intervention
Status
Target Date
Make a plan specific to your needs to include all participants in your we
In Progress
10/31/2013
New
Add
Attend self-help groups regularly


CareManager
Client
Anderson, Tom
Alerts
Tasks
Coordination
Notes
Plan
CareManager Plan
Care Coordination
Facesheet
Demographics
Consent Forms
Eligibility
Assessments
Problems
Care Coordination
CareManager Plan
Notes
Social Support Contacts
Medications
Vitals
Hallmark Events
Documents
CareConnect
Discharge
Behavioral Health
Keep mental health appointments/attend program as scheduled
Develop a relapse prevention/safety plan
Attend self-help groups regularly

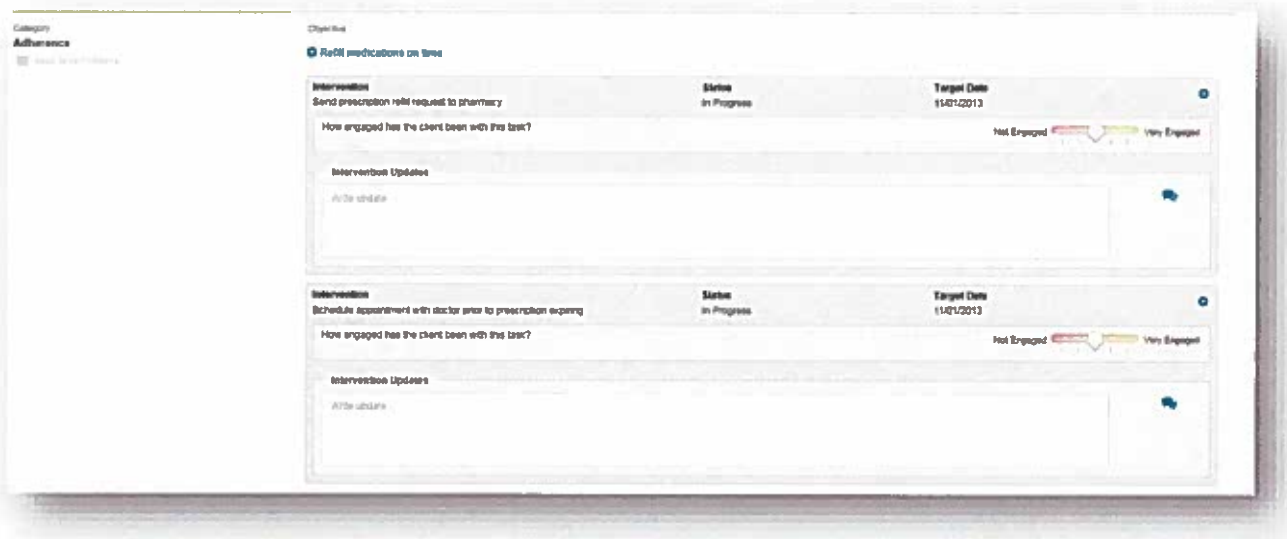
Providers can be assigned to care plan problems in the Care Coordination tab, and become part of the member's care team.



Netsmart

Care Manager Notes

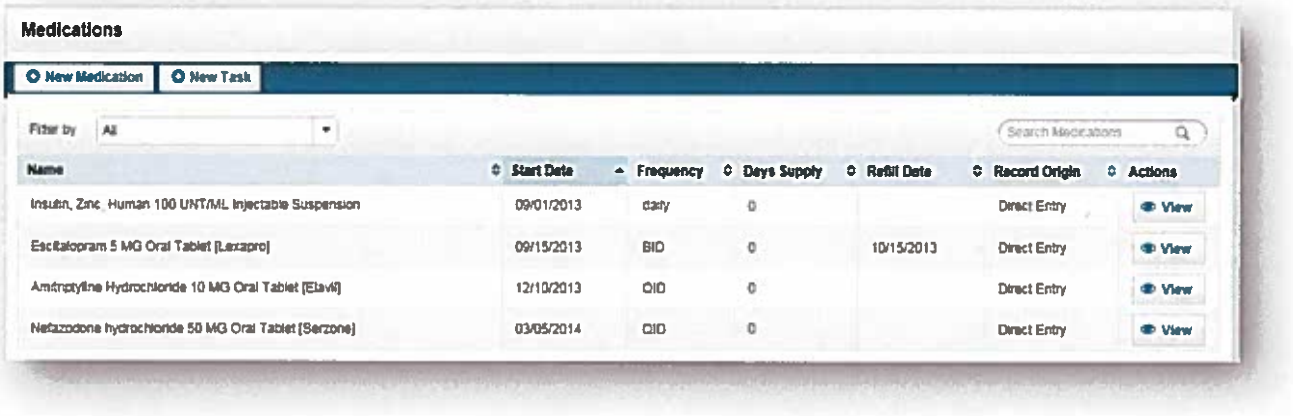
The notes provide a platform for the care manager to gauge and document activities, care plan progress, outcomes, barriers and member engagement.



Additional note types in CareManager: Contact note to document contact and activities by the care team, and Client Search note to document outreach activities and indicate enrollment or opt out and consent status.

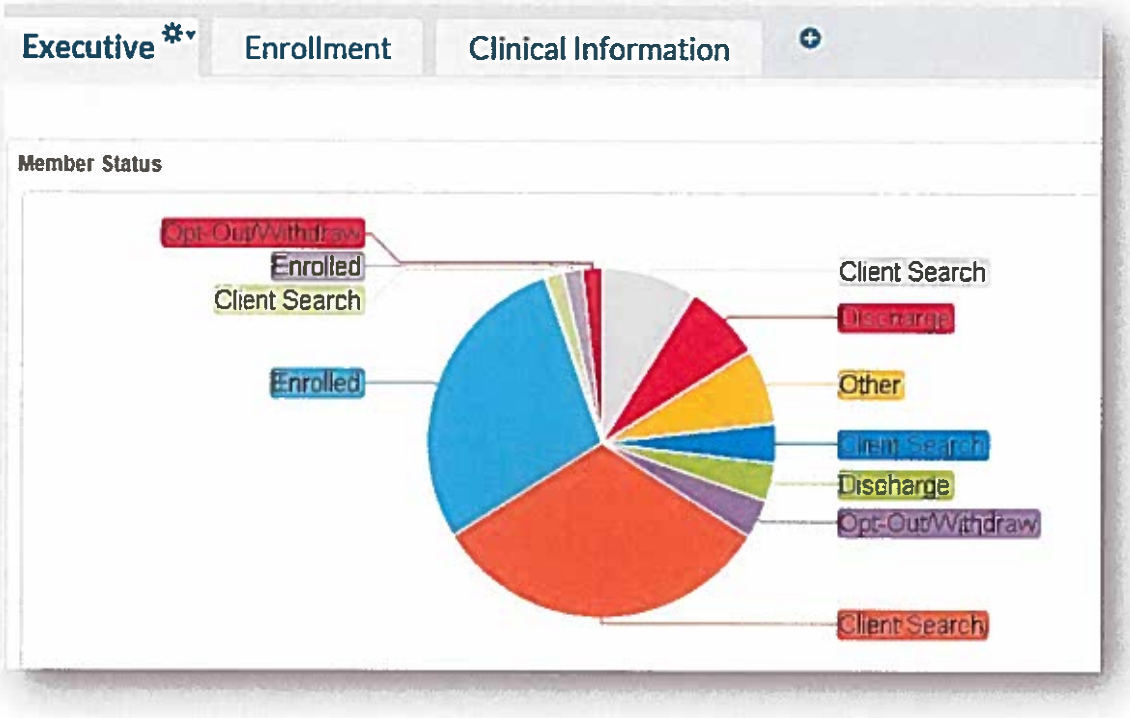
Member Medication List

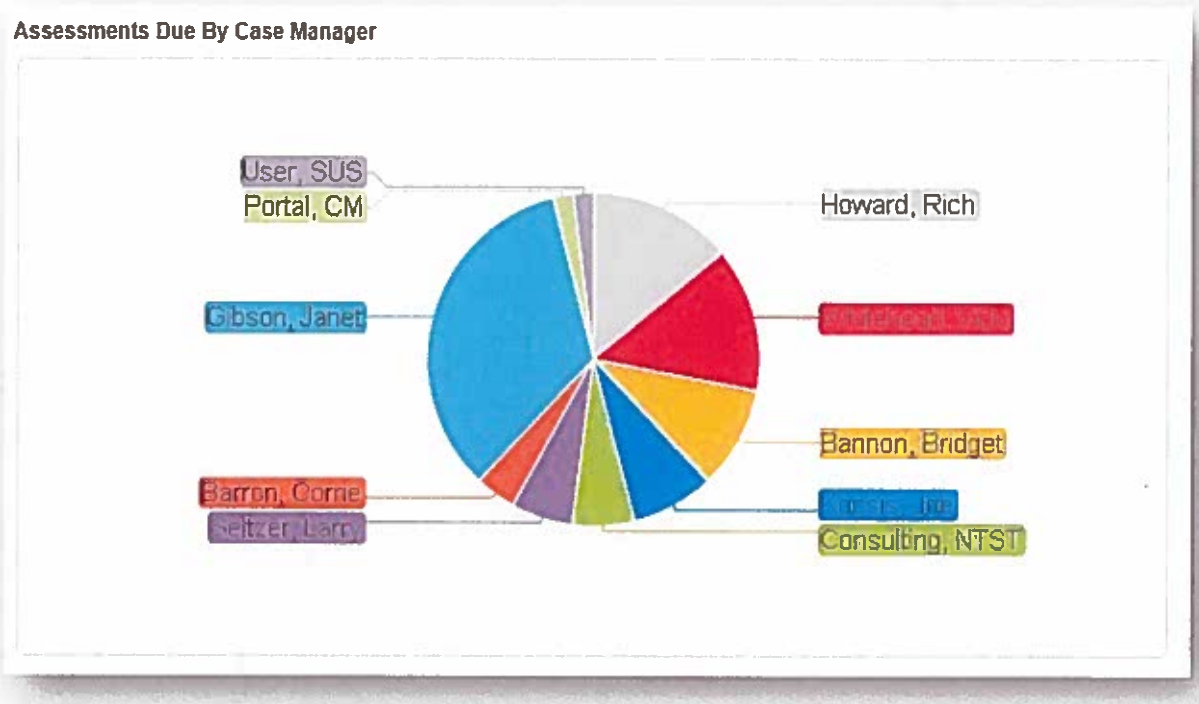
This screen is part of the member's clinical record which also includes Vitals, and Hallmark events; any clinical, behavioral or social events that impact that member's overall wellbeing and Care Plan.

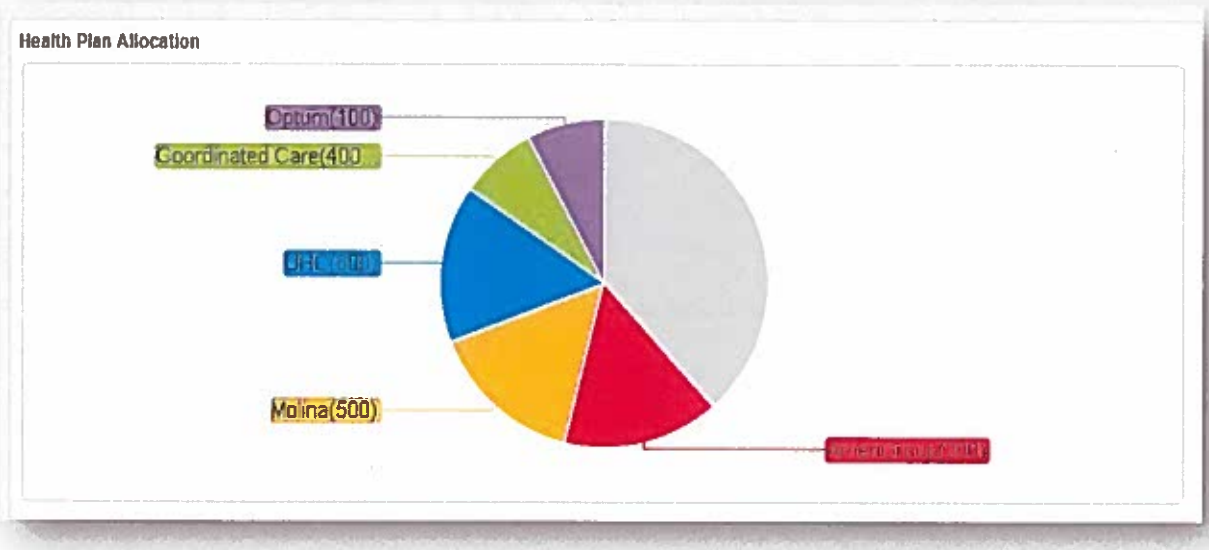


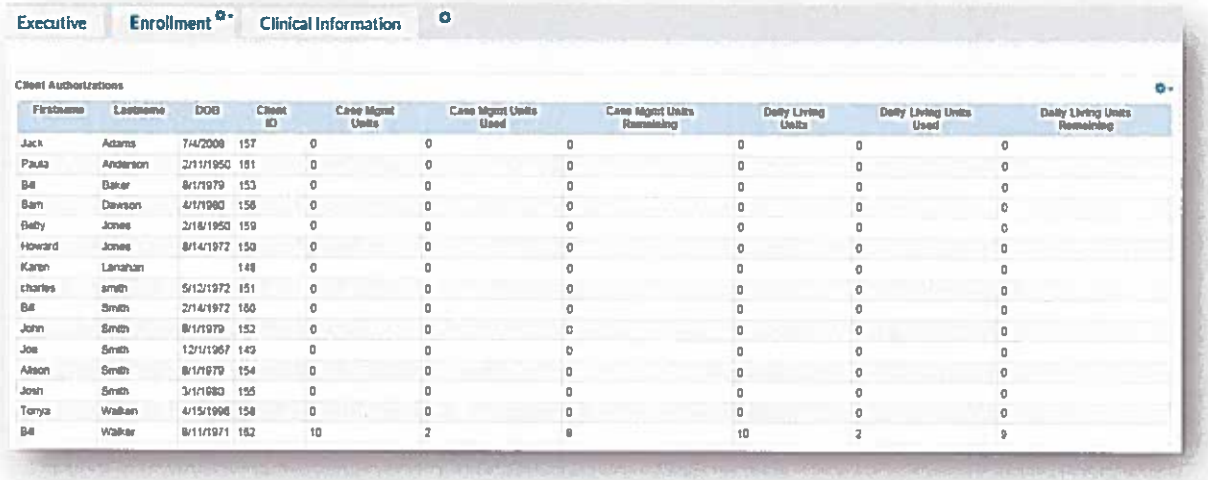
Dashboards and Reports

CareManager provides several dashboards to allow the organization to track overall performance, operational indicators, identify opportunities for clinical improvement and generate registries for targeted interventions. In addition, CareManager allows the organization to define its own reports via a robust reporting tool.


Executive
Enrollment
Clinical Information
Member Status
Opt-Out/Withdraw
Enrolled
Client Search
Enrolled
Client Search
Discharge
Other
Client Search
Discharge
Opt-Out/Withdraw
Client Search


Assessments Due By Case Manager
User, SUS Portal, CM
Howard, Rich
Gibson, Janet
Bannon, Bridget
Barron, Corne
Consulting, NTST


Health Plan Allocation
Optum(100)
Coordinated Care(400
Molina(500)



Executive | Enrollment | Clinical Information

Client Authorizations

Firstname	Lastname	DOB	Client ID	Case Mgmt Units	Case Mgmt Units Used	Case Mgmt Units Remaining	Daily Living Units	Daily Living Units Used	Daily Living Units Remaining
Jack	Adams	7/4/2008	157	0	0	0	0	0	0
Paula	Anderson	2/11/1950	151	0	0	0	0	0	0
Bill	Baker	8/1/1979	153	0	0	0	0	0	0
Sam	Dawson	4/1/1980	156	0	0	0	0	0	0
Betty	Jones	2/18/1950	159	0	0	0	0	0	0
Howard	Jones	8/14/1972	150	0	0	0	0	0	0
Karen	Lanahan		148	0	0	0	0	0	0
charles	smith	5/12/1972	151	0	0	0	0	0	0
Bill	Smith	2/14/1972	160	0	0	0	0	0	0
John	Smith	8/1/1979	152	0	0	0	0	0	0
Joe	Smith	12/1/1967	149	0	0	0	0	0	0
Alison	Smith	8/1/1979	154	0	0	0	0	0	0
Josh	Smith	3/1/1983	155	0	0	0	0	0	0
Tonya	Walker	4/15/1998	158	0	0	0	0	0	0
Bill	Walker	8/11/1971	162	10	2	8	10	2	8

Care Plans Due

Staff Name	Firstname	Lastname	Client ID	Plan Date	Days Since Plan	Care Plan Status
	Karen	Lanahan	148	12/12/2013	231	Over Due
	Josh	Smith	155			Over Due
	Ursula	Upton	146	11/1/2013	272	Over Due
	Bill	Baker	153	1/31/2014	181	Due Soon
	Alison	Smith	154	1/31/2014	181	Due Soon
	Erin	Summers	115	9/18/2013	316	Over Due
	Morgan	Thomas	106			Over Due
	Kristi	Merchant	112	12/2/2013	241	Over Due
	Peggy	Williams	147	11/25/2013	248	Over Due

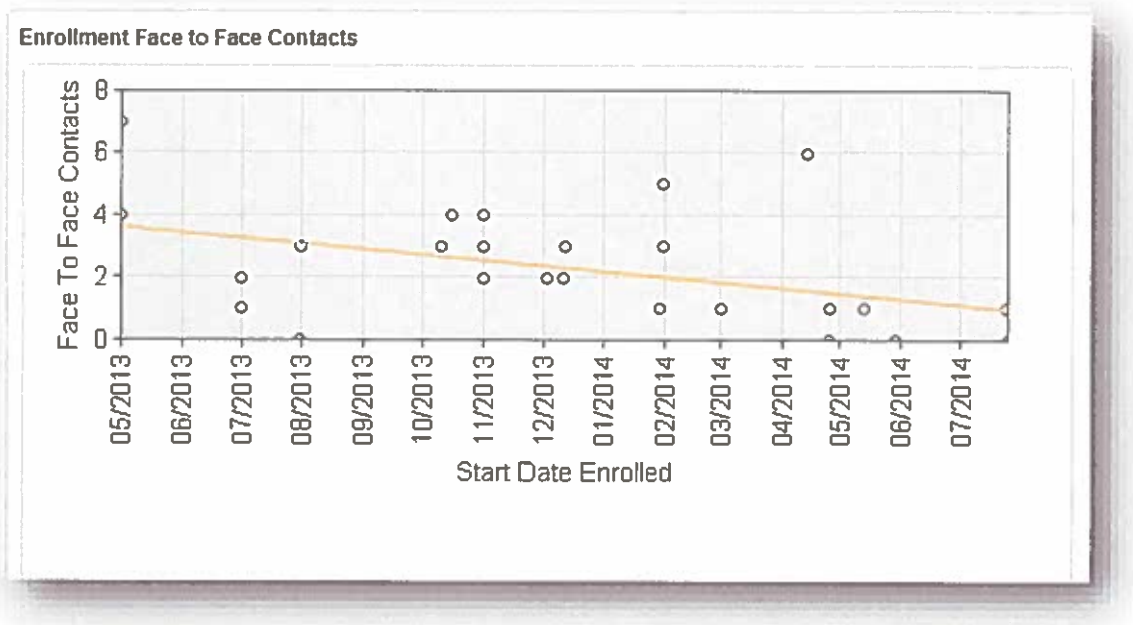
BMI Greater than 25

Page 1 of 2

Staff Name	Client ID	Firstname	Lastname	DOB	Bmi Teken Datetime	Body Mass Index
	156	Sam	Dawson	4/1/1980	04/16/2014 10:00 AM -04:00	26.63
	157	Jack	Adams	7/4/2008	04/25/2014 03:41 PM -04:00	27.46
	161	Paula	Anderson	2/11/1950	07/24/2014 12:34 PM -04:00	35.51
Barron, Corrie						
	144	Abby	Baker		04/01/2014 12:33 PM -04:00	29.95
	146	Ursula	Upton	11/13/1971	11/01/2013 10:53 AM -04:00	26.43
Consulting, NTST						
	153	Bill	Baker	8/1/1979	04/14/2014 01:14 PM -04:00	29.95
	154	Alison	Smith	8/1/1979	04/22/2014 09:44 PM -04:00	27.45
Gibson, Janet						
	101	Tom	Anderson	7/1/1971	03/20/2014 09:51 AM -04:00	47.34
	102	Todd	Brown	1/10/1978	04/15/2014 01:36 PM -04:00	38.74
	104	Daniel	Dresser	7/3/1974	04/08/2014 04:20 PM -04:00	30.89
	105	Christine	Mitchell	8/20/1982	04/15/2014 10:58 AM -04:00	26.88
	115	Erin	Summers	5/23/1979	09/10/2013 08:40 AM -04:00	29.12
	124	Steve	Anders	10/17/1978	03/31/2014 11:25 AM -04:00	34.51
Howard, Rich						
	144	Abby	Baker		04/01/2014 12:33 PM -04:00	29.95

Anti-Depressants and PHQ-9

Latest Record	Firstname	Middlename	Lastname	DOB	Client ID	Antidepressant Count	Phq Date	Phq9 Score	Days Since Phq9	Start Date Enrolled	Days Since Enrolled	PHQ9 Due
YES	Tom		Anderson	7/1/1971	101	1	6/24/2014	18	37	5/1/2013	456	Compliant
YES	Todd		Brown	1/10/1978	102	3	4/11/2014	27	111	5/1/2013	456	Overdue
YES	Christine		Mitchell	8/20/1982	105	2	3/3/2014	13	150	7/1/2013	395	Overdue
YES	Ursula		Upton	11/13/1971	146	1				12/3/2013	240	Never Done
YES	Karen		Lanahan		148	1	4/21/2014	18	101	12/12/2013	231	Overdue
YES	Wendy		Smith	1/1/1960	128	1	11/13/2013	26	260			Overdue
YES	Betty		Jones	2/18/1950	159	1	5/1/2014	14	91	4/25/2014	97	Overdue

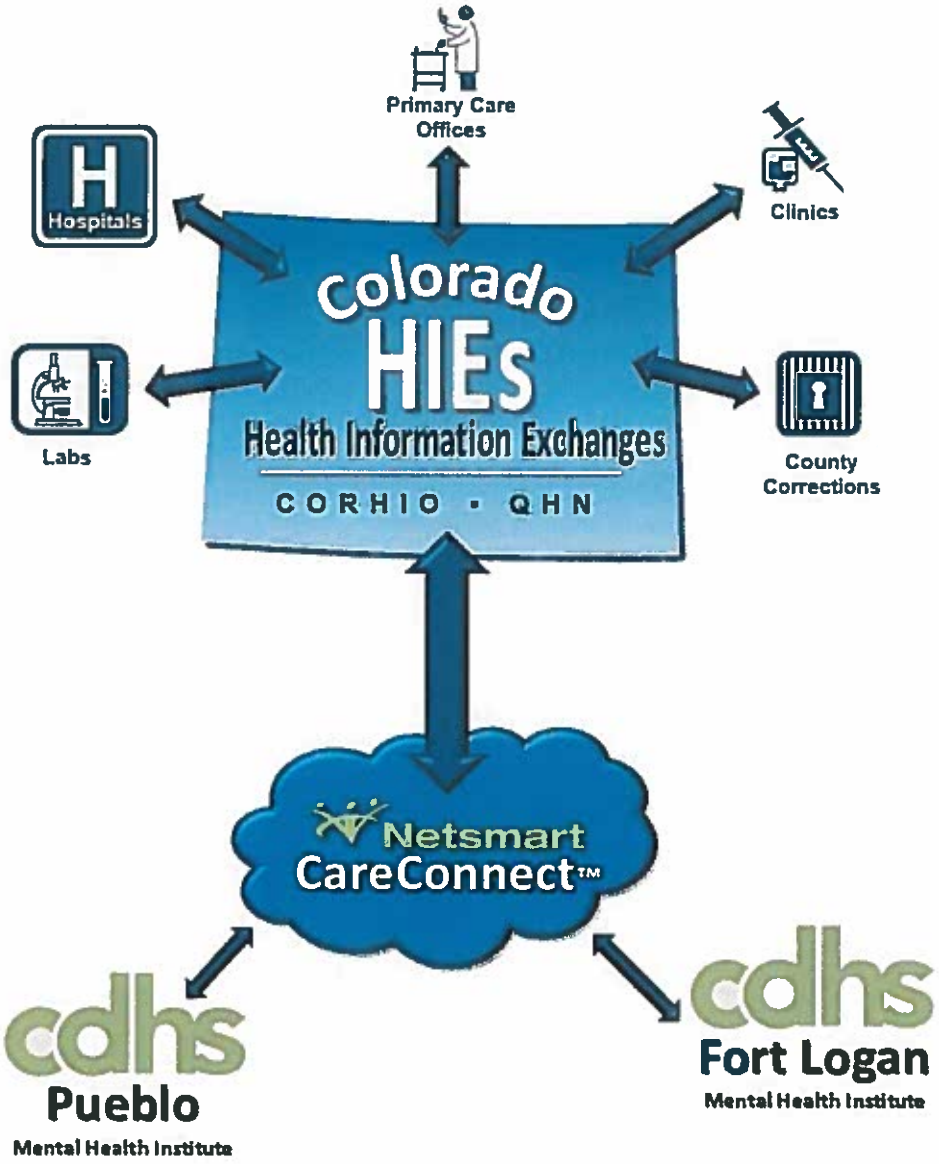

Enrollment Face to Face Contacts
Face To Face Contacts
0
2
4
6
8
05/2013
06/2013
07/2013
08/2013
09/2013
10/2013
11/2013
12/2013
01/2014
02/2014
03/2014
04/2014
05/2014
06/2014
07/2014
Start Date Enrolled

Colorado HIE Connectivity

In recent months, Netsmart responded to RFP NCRB1405035OBH Colorado Department of Human Services Comprehensive Electronic Health Record solution. Stated below are the plans proposed to increase coordinated care across the State of Colorado.

Colorado Department of Human Services

Connecting the Healthcare Community

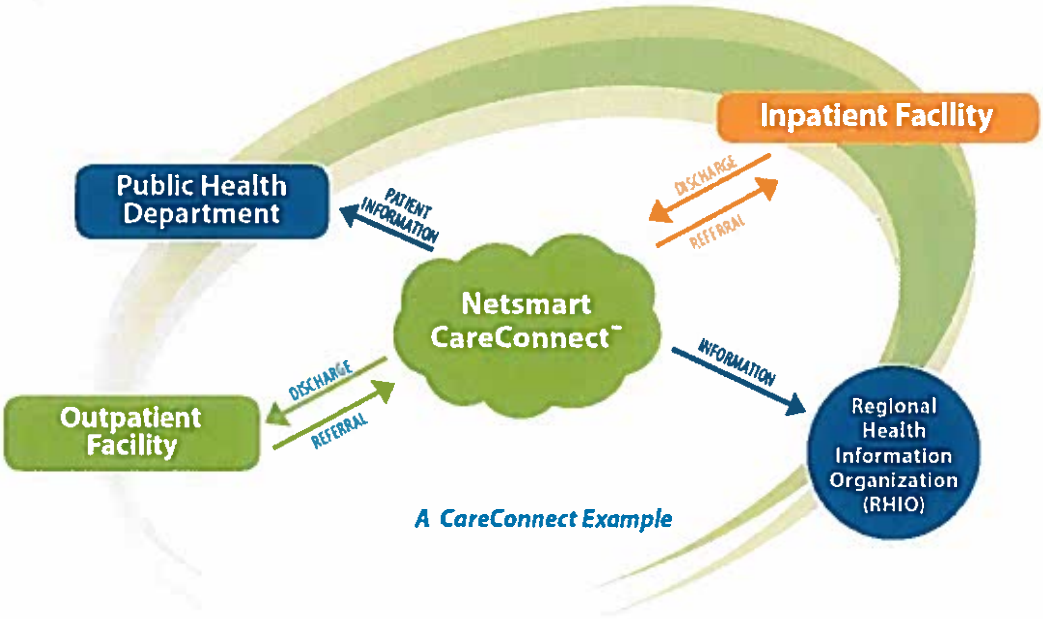


CareConnect functionality provides the ability to exchange health information electronically across statewide and regional providers in order to improve health care quality and safety, while connecting behavioral health and physical health communities. CareConnect™ has the unique capability to translate the files transmitted and received to match the formats required

by Netsmart's CareRecords as well as other EMR's, and the HIE operating systems. Once translated, CareConnect™ transmits the protected health information in a secure encrypted and auditable method.

Additionally, the HIE connection will allow the State of Colorado to pull transactions, or query through the Colorado Regional Health Information Organization (CORHIO) and Quality Health Network (QHN), allow a user to submit a request for patient information and ask the HIE entity to discover and provide any records it may have about the patient in accordance with policies governing patient consent and data use agreements between exchange users. CareConnect™ has the functional ability to register a patient within the HIE which will act as a Master Patient Index. Data embedded within Avatar will generate a Meaningful Use Stage 2 CCD and publish it to the HIE on a patient by patient basis. A query or call to the HIE can be sent directly from CareManager on a patient and the aggregated CCD will be transmitted back into the application and the data stored directly within the patient's chart.

Future CareConnect Possibilities



Overall, Netsmart is an innovative and dynamic company continuing to expand and build on not only the core Electronic Health Record offerings (MUII Certified) but all other technology needs that directly supplement an EHR's ability to assist in direct care to the communities we serve. While we are the leader for Behavioral, Mental, I/DD, Substance Abuse, and Public Health or the largest non-hospital and non-primary care EHR Company; our associates wake up each day dedicated to a much larger vision of an integrated health care world. Netsmart, the State of Colorado, and its partners have already, and will continue, to become more efficient and effective in what we do. It is our intent to stay focused on the integrated health care model Colorado intends to achieve.

Corporate Responsibility

Beyond digitization, our solutions focus on the delivery of care, the path to recovery and ensuring every person has access to care. To further support of our cause connected focus, Netsmart created a not-for-profit organization called **EveryDayMatters Foundation™**. The purpose of **EveryDayMatters Foundation™** is to provide funding and education to end the stigma associated with mental health challenges. The site offers clinicians, practitioners, consumers and community members a place to share stories, celebrate successes and become inspired. It is a forum aiming to end stigma surrounding mental and public health.

For more information, visit www.everydaymatters.com

NETSMART RESPONSE:

Netsmart is providing input and comments for Health Information Technology (HIT), questions 77 - 90.

Health Information Technology (HIT)

77. ***Types of communication. For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:***

NETSMART RESPONSE:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒

Text message	☐	☒
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☐	☒
Smartphone app	☐	☒

Other:
Ranking:

1. Phone
2. Email
3. Web Portal
4. Face-to-Face
5. Smartphone
6. Text Message
7. Telemedicine/Video chat

78. ***HIT investments by organizations. For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:***

NETSMART RESPONSE:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☒	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☒	☐
Practice assessment tools	☒	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☒	☐
Shared decision-making tools	☒	☐
Telemedicine software	☐	☒

Other: Connection Services (CareConnect)	☒	☐
Other:	☐	☐

79. ***Importance of technology by type. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:***

NETSMART RESPONSE:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☐	☐	☒
Health risk assessment software	☐	☐	☐	☐	☒
Practice management tools (scheduling, billing)	☒	☐	☐	☐	☒

Client web portal for communicating care plan, services, benefit enrollment	☐	☒	☐	☐	☒
Patient education wellness tools	☐	☐	☐	☐	☒
Provider/case manager directory	☐	☐	☐	☐	☒
Shared decision-making tools	☐	☐	☐	☐	☒
Telemedicine	☐	☐	☐	☐	☒
Other: Connectivity to CORHIO, QHN (HIEs) or other networks. Netsmart's CareConnect tool can operate in place of an HIE.	☐	☐	☐	☐	☒

80. ***What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?***

NETSMART RESPONSE:

The main barriers most RCCOs and providers encounter in integration of health information technology are multifaceted:

1. For those patients with substance abuse diagnosis, 42 Code of Federal Regulations ("CFR") Part 2:
   - 42 CFR Part 2 applies to any individual or entity that is federally assisted and holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment (42 CFR § 2.11). Most drug and alcohol treatment programs are federally assisted. For-profit programs and private practitioners that do not receive federal assistance of any kind would not be subject to the requirements of 42 CFR Part 2 unless the State licensing or certification agency requires them to comply. However, any clinician who uses a controlled substance for detoxification or maintenance treatment of a substance use disorder requires a federal DEA registration and becomes subject to the regulations through the DEA license.

- The regulations restrict the disclosure and use of alcohol and drug patient records which are maintained in connection with the performance of any federally assisted alcohol and drug abuse program (42 CFR § 2.3(a)). The restrictions apply to any information disclosed by a covered program that "would identify a patient as an alcohol or drug abuser ..." (42 CFR §2.12(a) (1)). In laymen's terms, the information protected by 42 CFR Part 2 is any information disclosed by a covered program that identifies an individual directly or indirectly as having a current or past drug or alcohol problem, or as a participant in a covered program.
  - With limited exceptions, 42 CFR Part 2 requires patient consent for disclosures of protected health information even for the purposes of treatment, payment, or health care operations. Consent for disclosure must be in writing.

2. In the current fee-for-service system, there is no financial incentive for integration. The upcoming pay-for-performance reimbursement models will require integration and treatment of both physical, mental health and substance abuse treatments holistically.
3. Lack of funding to support the data integration and data connectivity of RCCOs and providers. At Netsmart, we offer a low-cost of ownership product call CareConnection – which essentially can act as the connectivity agent all the way through to the creation of a Health Information Exchange. We currently use this product with CORHIO to community behavioral/health care providers and are expanding our relationship with QHN.

81. ***How can Health Information Technology support Behavioral Health Integration?***

NETSMART RESPONSE:

Behavioral health conditions, including mental illness and substance use disorders, are widespread among Medicaid's high-need, high-cost beneficiaries, many of whom also have chronic physical conditions. Over half of all Medicaid beneficiaries with disabilities are diagnosed with a mental illness. For those with common chronic conditions, health care costs are as much as 75 percent higher for those with mental illness compared to those without a mental illness and the addition of a co-occurring substance use disorder results in two- to threefold higher health care costs. Among individuals eligible for Medicare and Medicaid (also known as dual eligible individuals), 44 percent have at least one mental health diagnosis. For the 20 percent of dual eligible individuals with more than one mental health diagnosis, annual spending averages more than $38K—twice as high as average annual spending for the dual eligible population as a whole. The prevalence of serious mental illness is especially high

among dual eligible individuals under age 65 – at least three times higher than for those age 65 and older. Meanwhile, substance use disorder, with and without co-occurring mental illness, is also more common among dual eligible individuals than among Medicare-only beneficiaries.

Yet despite the complexity of their needs and the array of services they require, most individuals with both physical and behavioral health conditions are in fragmented systems of care with little to no coordination across providers, often resulting in poor quality and higher costs. Today, as health policymakers nationwide seek to transform the delivery and costeffectiveness of publicly financed care, states are intensifying efforts to develop managed and integrated care models for this complex need population.

The supporting technologies are a critical component to realizing care coordination and primary care integration. As health and human services providers become critical players in coordinating care between a wider range of providers and consumer populations, they need solutions that enable cross-organizational case management. Providers working in the roles of health homes, or designated organizations responsible for the coordination and management of care for identified consumer populations, require innovative solutions that enable and support this broader spectrum of services and related clinical data exchange.

Netsmart CareManager facilitates coordinated care across providers and offers the ability to exchange consumer data, track clinical quality measures and outcomes, and manage authorizations and claims across providers. CareManager gives access to all consumer records for which users are authorized. This comprehensive view into a consumer's health record provides broader insight and visibility into the activity taking place within the provider network.

This visibility allows your organization to make informed decisions and real-time course corrections to ensure the patient is receiving the appropriate care, at the appropriate location, at the appropriate time. Additionally, CareManager provides alerts, clinical decision support, utilization management and stratification of the population by acuity.

In this emerging era of accountable care, organizations are increasingly being required to track designated quality measures to demonstrate improved outcomes. CareManager provides reliable methods for tracking the specific quality measures for which they will be held accountable. Additionally, CareManager enables the exchange of authorizations and supports claims management, so clinical records, billing information and payments are managed from a central location.

In addition, to accomplish true integration, the need for connectivity is paramount. Netsmart's CareConnect acts as the conduit providing The CareConnect network connects providers, hospitals, physicians, HIEs, and integrated delivery networks to improve efficiency and reduce the cost of healthcare. Participating in a network via CareConnect also supports Stage 2 Meaningful Use requirements. CareConnect supports all federal and state policies and standards for health information exchange, including privacy and security standards (such as HIPAA and state law), technology interoperability standards (such as Direct), and message types (such as HL7 and CCDA). CareConnect is integrating the largest connected network of behavioral health providers, leading health systems, laboratories for electronic exchange of lab orders and results, HIEs for CCD exchange, and public health/meaningful use reporting. The CareConnect Network for Clinical Interoperability allows clinical care information, including clinical messages, immunization summaries, CCDs, referrals, discharge summaries and lab results to be transmitted within a client's own organization, between providers and practices within the larger healthcare community, and health systems locally and nationally across all technology platforms.

82. In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

NETSMART RESPONSE:

There should absolutely be resources dedicated to data and analytics. We believe our experience with Enlighten Analytics will allow the functionality desired under this RFI. In previous installations of Enlighten Analytics, Netsmart has deployed the solution to a large number of behavioral health organizations where a member organization or single entity has access to a centralized aggregated view. Because of the architecture of Enlighten Analytics, the tool does not expose any patient/client identifiable information. The tool can be used to analyze large amounts of clinical, operational and financial data and is designed to find trends within an individual organization or across a state enterprise.

Enlighten Analytics is an award winning business intelligence tool. Enlighten Analytics is an innovative, interactive, easy-to-use platform specifically designed for behavioral health organizations. It captures revenue, cost, productivity and quality outcomes data and reporting in simple-to-interpret charts and graphs, effectively turning the massive amounts of complex data that behavioral health providers collect into meaningful, actionable information. This is part of Netsmart's commitment to advancing patient care and equipping its clients in preparing for the shifts in the healthcare economy. These also includes the integration of predictive modeling algorithms in clinical care and the promotion of innovative ways to leverage EHR transaction data to enhance clinical decision support and improve the accuracy and efficacy of patient diagnosis and treatment.

Enlighten Analytics gives behavioral healthcare providers understandable charts that provide a clear picture of their organizations' strengths and weaknesses. Organizations and statewide enterprises that have implemented Enlighten Analytics have experienced dramatic improvements in clinical productivity, patient access to services, and clinical quality.

With Enlighten Analytics, behavioral health providers can:

- Give care coordinators, case managers, therapists, psychiatrists, nurses, and peer specialists up-to-date, actionable information that helps them improve patient access and transform care.
- View key agency targets related to revenue, cost, staff productivity, and quality outcomes.
- Analyze, report, and predict revenue at the staff, clinic, and regional levels and review revenue totals by location, change over time, trending, and service type.
- View detailed information on kept service rates, including trending over time on kept appointments.
- Managers can look at individual categories (i.e. individual therapy) and see how kept rates vary by payer, various codes, day and week, and specific location.

- Identify and track service utilization rates. This is essential for behavioral health providers wishing to become health homes or successfully participate in Accountable Care Organizations. This breakthrough technology can promote data-driven decision making and improve the quality of behavioral healthcare services across the United States.

83. ***Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.***

NETSMART RESPONSE:

Yes. A shared care management tool is critical to increasing outcomes while driving down costs. The basic criteria and functionality of that tool would need to include the ability to:

- Manage population health
- Exchange client/consumer data securely
- Coordinate care across providers

- Track clinical quality measures and outcomes
- Exchange data
- Coordinate care across providers
- Track clinical quality measures and outcomes
- Manage authorizations and claims across providers

84. ***Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.***

NETSMART RESPONSE:

Yes. Population health management is a critical component of care management and care coordination. The population health management functionality aggregates clinical data to provide a broad picture at the population level. Stratifying the population by risk level will allow a care manager to engage individuals who require immediate attention. Providing visibility into the population and their needs will allow your organization to take innovative approaches to improve the population's health status.

85. ***Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.***

NETSMART RESPONSE:

Medicaid provider directory functionality should include a database of Medicaid providers via a web portal. The system should have the ability to do a "quick search" by entering searchable text (e.g. name, location, type, etc.). Additionally, an advanced search capability that would include a zip code search, search to find providers near an address, search by specialty. As we move toward accountable care and pay for performance, it is suggested that in the future, a consumer/client review be added for each provider.

86. *How can the RCCOs support providers' access to actionable and timely clinical data?*

NETSMART RESPONSE:

The RCCOs would support provider's access to actionable and timely clinical data by aggregating that clinical data to provide a broad picture at the population level. Stratifying the population by risk level will allow a care manager to engage individuals who require immediate attention. Providing visibility into the population and their needs will allow a provider organization to take innovative approaches to improve the population's health status.

It would have to provide easy access to treatment planning, notes, assessments.

Additionally, it would need the ability to link the treatment plan, progress notes and other results back to the plan of care the care management and care coordination entities are utilizing.

Also, the need to have some "connectivity" between the Care Management Plan and the provider's Treatment Plan.

87. *What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.*

NETSMART RESPONSE:

Netsmart proposes its CareManager and CareConnect solutions as previously described. With increasing pressure to coordinate care across the full spectrum of providers and better treat individual populations, health and human services organizations need solutions that enable cross-organizational care management. Taking a step beyond the recent initiative to simply connect provider organizations and share an individual's data, the newest federal goals aim to designate responsible organizations to coordinate and manage the care of identified populations of individuals.

These initiatives are bringing sweeping changes across the healthcare industry. Netsmart is at the forefront of healthcare reform with new solutions to enable the coordinated care management. Netsmart's CareManager and CareConnect solutions address these needs in the most comprehensive manner available in today's market.

88. ***What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.***

NETSMART RESPONSE:

The RCCO's should supply a centralized team of helpdesk members and make available regional subject matter experts out in the field. The number of associates required would vary based on total number of end users and level of technical expertise needed. For the CareManager platform, a team of level 1 helpdesk members would address general questions as it relates to access to the web portal. This team should also be responsible for organized communication to users and be able to provide general help.

89. ***What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?***

NETSMART RESPONSE:

CORHIO and QHN are the hub of connectivity and vital should they prove to be flexible and have the ability to adapt to the rapid changes needed in this RFI and beyond. Netsmart's CareConnect solution will support connecting to the existing networks or could become the overall connectivity tool needed for the ACC or State of Colorado.

90. *Please share any information, advice, and suggestions you have about health information technology in the ACC Program.*

NETSMART RESPONSE:

Please review our attachment in the "Attachment" Section of the RFI. We would appreciate the opportunity to speak in depth about the details of connectivity and a Care Management tool that can accommodate. Flexibility, innovation, and dedication to optimization of any HIT network and ACC program will continue to be a priority across the country as every State, County, Community, or ACC organization will require/request viable solutions to improve outcomes. The technology and the technology partner need to be willing to collaborate and accommodate as needed while also provide expertise from their experience in other settings.

Netsmart is committed to transforming the way care is delivered. Through innovative and interactive solutions and services, we will lead the charge in the era of accountable care, just as we did with Meaningful Use. Our obligation is to guide our clients through this rapidly changing environment by providing them with technology and services to help improve outcomes and reduce costs. We will help each of our clients adapt to these changes so that they can their goals and improve the health of the populations they serve.

At Netsmart, we are at the forefront of healthcare reform. We are continuing to innovate and evolve our services and solutions to meet the needs of our clients today and in the future. We are committed to ensuring that our clients in behavioral health, public health, substance abuse and addiction services emerge from the healthcare reform era as the leaders in their respective fields of specialization. Our belief is these attributes are necessary for the State of Colorado to achieve what is outlined in this RFI.

Model for the Nation

KANSAS BEHAVIORAL HEALTH AGENCIES AND NETSMART PARTNER ON HEALTH HOMES INITIATIVE TO DRIVE COORDINATED CARE

Industry
- Behavioral Health

Location
- State of Kansas

Challenges
- New legislation requiring health home implementation

Solution
- CareManager™

Results
- Member health homes can share information
- Increased care coordination
- Efficient, effective services to Medicaid clients across the state

On July 1, 2014, the State of Kansas began a health home program for people with serious mental illnesses (SMIs). The goal of the Kansas health homes: to improve health outcomes for those with chronic conditions, to reduce the number of people who are unnecessarily admitted to the hospital and to reduce emergency room visits.

Any of the roughly 426,360 local Medicaid recipients with an SMI are eligible for the program.

In recent years, clinicians have come to know that the opportunity to treat the body and the mind in one workflow is instrumental to giving individuals the treatment they need, especially in cases of co-morbidity or chronic illness. Sixty eight percent of adults with mental health conditions also have medical conditions, according to the American Psychological Association. If you treat both the mind and the body at the same time, you drive down costs and you drive up outcomes. It's a win-win.

This message became even clearer in 2010 with the passing of the Affordable Care Act, which in part focuses on the need for more effective continuity of care. To make this possible, the healthcare professionals responsible for care need to be able to share authorized clinical information and to smoothly facilitate referrals.

In Kansas this vision became a reality on Aug. 1, 2014 with the implementation of Netsmart's CareManager solution in 23 of the state's 26 Association of Community Mental Health Centers of Kansas Inc. health homes.

CareManager aggregates clinical data to provide a broad picture at the population level, facilitates care coordination across providers, tracks clinical quality measures and outcomes, and manage authorizations and claims across care providers. The solution is designed to work directly with care coordinators performing outreach and care management activities.

"Being able to come together under a single, standardized data platform will allow 23 member health homes to share information, coordinate care and provide efficient, effective services to clients across the state."

– Kyle Kessler, Executive Director of The Association of Community Mental Health Centers of Kansas (ACMHCK)

"The Kansas mental health system is shared between the state and the counties, and sharing is a big part of what makes the system work," said Kyle Kessler, executive director of the Association of Community Mental Health Centers of Kansas (ACMHCK), which oversaw the

Netsmart

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 038

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Nikki Brezny
Location: Denver, Denver, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Coalition for the Homeless, Stout Street Health Center
Location: Denver, Denver, Colorado
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: PCMP, Behavioral Health, Dental, Pharmacy, Vision, Housing
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): FQHC serving the homeless

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Quarterly meetings with RCCO Region 5 - Colorado Access

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Program manager for Medicaid Outreach and Enrollment

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

☐ 2-3 years
☒ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Conversations on how to make it better
- With Medicaid expansion, safety net providers are receiving improved compensation.

2) What is not working well in the ACC Program?

- No recognition, enhanced compensation or performance alternatives for facilities or organizations that work with special populations such as homeless people.
- Not all Medicaid enrolled persons are in the ACC or attributed to a PCMP
- Passive attribution has deteriorated the reliability of SDAC data.
- Population management and KPI management is challenging due to inaccurate attribution.
- SDAC data is "old" information as it is based on claims paid information.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

- Leadership at the Mental Health Center level is more committed than ever to establishing and implementing best practices. As a result of Medicaid expansion, the Mental Health Centers are hiring new staff to accommodate the demand on services from hundreds of thousands of newly eligible Medicaid patients.
- In addition, the mental health community is aware that the system is dysfunctional, which is forcing people to look for ways to improve. The services that are provided, once a patient is able to access them, are very strong.

4) What is not working well in the BHO system?

- Even with the effort to create more staff positions to meet the increased demand on services, there are not enough staffing resources available to fund those positions. Salaries are being inflated to be comparable to the competition, which could have serious long-term impacts on the capacity to serve. This is particularly true with homeless service providers, who are not able to keep up with the competition created by larger mental health organizations who can afford to pay their staff more.
- There is a lack of hospital beds, therefore length of stays are not adequate. It also remains to be seen how the crisis response system will work.
- Funding is bifurcated and evaluations are still separate, which doesn't create a real system of integrated care. By funding new "integrated services," funding could be in jeopardy for groups that have been experts

at providing care for years. There is still a mindset that co-located means integrated, when integrated should be focused on seamless care.

- Access to services is still a huge problem. The system may be getting better in terms of providers and availability of resources but it means nothing if patients are not able to access the care.
- Behavioral health care for children is almost non-existent.

5) What is working well with RCCO and BHO collaboration right now?

- Reasonable accommodation standards are helping to build relationships.

6) What is not working well with RCCO and BHO collaboration right now?

- The relationship between RCCO's and BHO's depends on the RCCO. For example, Access has been very accommodating while others are not willing to accommodate a structure for the BHO's – they appear to be stuck within their old systems.
- The BHO's are not always culturally sensitive to the homeless population, there are archaic methods in place (paperwork, preauthorization, etc.) that need to be revamped.
- The RCCO's need to develop new payment structures. For example:

a. Respite care – what do we do with people once they are discharged from the hospital?

b. Non-clinical case management services – there needs to be a payment structure for services provided outside of a clinical setting (i.e., while driving a client to an appointment) and for services such as housing counseling.

c. Continuity of care is not supported financially by the RCCO's

- The levels of regulations and mandates are onerous, more time is spent on paperwork with each new system that is created. Time with patients is compromised.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- Integration of care is critical. Behavioral health and primary care need to be put on an even playing field, rather than continuing the notion that behavioral health care is second class, or an "add-on" to primary care.
- The mental health community needs to get creative, how can services be replicated? The community knows how to provide services, there is no need to reinvent the wheel, but how can best practices be fostered and replicated?

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	
Community Behavioral Health Services Rule	☒	☐	
Covered diagnoses list	☒	☐	
Different behavioral / physical health reimbursement	☒	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	
PCMP financing structure	☒	☐	
Per-member per-month amount	☒	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☒	☐	
Professional / cultural divisions	☒	☐	
RCCO or BHO contracts	☒	☐	
Staff capacity	☒	☐	
State/Federal rules or reporting requirements	☒	☐	
Technical resources / data sharing	☒	☐	
Training	☒	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

- Shared Electronic Health Record among all programs and specialty care provided within the facility.
- Comprehensive and collaborative Patient Care Plan updated or reviewed at every face to face visit.
- Recognizing Integrated care is not the same as co-located care.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

Care coordination is an approach to healthcare in which all of a patient's needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the patient and the patient's caregivers, and works with the patient to make sure that the patient gets the most appropriate treatment, while ensuring that health care is not accidentally duplicated. This process appears to save money on health care costs and it improves the quality of care as well as patient satisfaction.
The approach of care coordination is used for patients with special health care needs who require long term health care. Someone with the sniffles does not need this service; an older adult suffering from several chronic illnesses does, just as a child with developmental disabilities can benefit from it. Care coordination can also be used to help people recover from serious accidents or strokes, to manage mental health conditions, and to assist patients with comorbidities.

b. How should RCCOs prioritize who receives care coordination first?

- RCCOs should only be involved when a member directly contacts the RCCO and then should make contact with the appropriate facility or organization.
- We have found RCCO data which is based on past claims submission to be out dated by a minimum of two months.
- We have found inaccuracies with attribution. For example: 15% of the children reported as not having a Well-Child check in the last 12 months in the SDAC database for claims paid through September 2014 were not Coalition patients.

c. How should RCCOs identify clients and families who need care coordination?

- RCCOs should only be involved when a member directly contacts the RCCO.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

- With the designation of *delegated Medical provider* comes the responsibility to track care coordination. Perhaps the delegate agency should be audited by the RCCO or HCPF for compliance.

12) What services should be coordinated and are there services that should not be a part of care coordination?

- To appropriately meet the needs of our homeless population all services that patients/clients are requesting or need must be coordinated including: housing, income and public benefits acquisition, transportation, nutrition and SNAP, family support and integrated health care services.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

- Homeless status: Coordinating the care of someone who is living outdoors is uniquely different than that for someone who is staying with a friend or family member. For example: An insulin dependent diabetic living on the street has no method of keeping insulin at the required temperature. Coordinating this person's care is significantly more intense than someone who may have daily access to a refrigerator.
- Food and income source
- Receiving medical, mental health care or case management anywhere else.
- Preferred language
- Transportation needs

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	Should the RCCO have a role? No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☒	

Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☒	☐	☒	
Education	☒	☐	☒	
Environment	☒	☐	☒	
Food access / nutrition	☒	☐	☒	
Health literacy	☒	☐	☒	
Housing	☒	☐	☒	
Language or translation services	☒	☐	☒	
Literacy	☒	☐	☒	
Transportation	☒	☐	☒	Bus passes and taxi vouchers are more effective and useful for homeless persons than the RCCO contracted transportation vendor
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	**Coordinate care?** Yes	No	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☒	☐	

Certified Addiction Councilors	☒	☐	
Certified Nurse Midwives	☒	☐	
Community Health Workers	☒	☐	
Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☒	☐	
Licensed Mental Health Counselors	☒	☐	
Licensed Professional Counselor	☒	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	
Nurse Practitioners	☒	☐	
Patient Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☐	☐	
Psychiatrists	☒	☐	
Psychologists	☐	☐	
Registered Nurses	☒	☐	
Social Workers	☒	☐	
Wraparound facilitators	☐	☐	
Other	Street outreach workers and case managers		

17) **Care coordination requirements for specific populations**. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☐	If homeless
Children	☒	☐	If homeless

Children who are healthy, but in socially-complex environments	☒	☐	
Children involved in the foster care system	☒	☐	
Children with a chronic illness	☒	☐	
Children with a serious emotional disturbance	☒	☐	
Children with medical complexity	☒	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	
Transition-age adolescents	☒	☐	If homeless
Parents and families	☒	☐	If homeless
Pregnant women	☒	☐	If homeless
Adults	☒	☐	If homeless
Adults who are healthy, but in socially-complex situations	☒	☐	
Adults with a chronic illness	☒	☐	
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	
Clients involved in the criminal justice system	☒	☐	
Clients with a disability	☒	☐	
Clients in a nursing facility	☒	☐	
Elderly clients	☒	☐	
Frail elderly clients	☒	☐	
Clients in palliative care	☒	☐	
Other populations, please comment: Homeless or at risk of homelessness. Living in a shelter, motel, halfway house, temporarily staying with a friend or family member.			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

- Unknown. We do not differentiate an ACC member from a straight Medicaid covered person from an uninsured person. Care coordination is available and provided for all persons.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

- Yes. Perhaps by the volume of care coordination items that the member needs. For example: homeless persons (given they are acknowledged as a specific population) have significantly more care coordination items than a stably housed person.

21) 5hould there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

- Without substantial financial support for organizations to staff care coordinator positions it may be an unfair requirement

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

- Did the member's health improve?
- Were barriers to access to care and interactions with systems removed?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

- Standardized reporting and auditing housed in a shared database for all regulatory agencies to access for compliance

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

- What was not helpful was the passive enrollment to Denver Health for anyone with a Denver county zip code. Homeless person often do not have an address to receive mail. In enrolling these persons in Medicaid the Coalition's address was used. The enrollment notices and information to choose a PCMP or be defaulted to Denver Health were never received by most homeless persons. Our Certified Application Counselors did their best to educate persons on the importance of choosing a PCMP. However, it is important to consider special populations such as the homeless and work with organizations such as the Coalition to find a more appropriate and equitable attribution system.

- As more providers become delegate agencies with higher PMPM payments the more critical the accuracy of attribution becomes. The risk of non-collaboration between agencies may be an issue.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

- Specialty care continues to be scarce. Our patient navigators are consistently frustrated by specialist's waiting lists and restricted access of accepting one Medicaid patient per month.
- It is vital that respite care for homeless individuals be available at a scope to meet the population need.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

- Specialists often will not work with our homeless persons as they are perceived as unreliable in keeping scheduled appointments. With appropriate transportation (bus passes, taxi vouchers, Coalition vehicles and case manager private vehicles) homeless persons can be better served in keeping appointments.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

- It is difficult to impact the high cost of our homeless using hospitals when there is not effective or timely communication and sharing of information that our attributed members received hospital care. It would be helpful if hospitals were incentivized to develop bidirectional electronic sharing of patient information.

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

- Willingness to develop relationships with organizations serving special needs populations such as homeless persons and willingness to undergo training in order to adapt practice guidelines appropriate to the needs of homeless patients.

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

- Financial support for alternative methods of transportation. As previously stated, bus passes, taxi vouchers and Coalition fleet and staff private vehicles is the most appropriate and culturally sensitive method to facilitate access to care for homeless persons.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47) **Community Health Worker reimbursement**. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

- Providers serving homeless patients must understand the special and complex health care needs presented and must adapt practice patterns accordingly.

b. What RCCO requirements would ensure cultural competency?

- Required training to understand the unique healthcare needs of homeless patients; the Colorado Coalition for the Homeless

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

- Diversity training

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

- Perhaps preferred (and appropriately compensated) facilities and organizations that demonstrate compassion and competency with special populations.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

- Focus on Colorado. Support a task force to study what the special needs of each region are and what could be the most useful to make a difference.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☒	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☐
Provide directory of other resources	☒	☐	☐	☐
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

- A tiered system based on complexity of population served

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?
- Most KPIs focus on the cost of providing care. Measuring the improvement in member's health is what matters.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement
- Based on improvement of members health and an official recognition or consideration for providers that serve special populations such as homeless persons.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☒

If you checked the "Other" box, please describe payment frequency below:

- bi-annually

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

- Health outcomes. No

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☒
Smartphone app	☐	☐
Other: homeless patients have complex communication needs and encounter frequent barriers not relevant to the housed population		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☒	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☒
Patient education/wellness tools	☒	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☒	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☒	☐	☐
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☒	☐	☐
Health risk assessment software	☐	☐	☒	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☒
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☒	☐	☐
Telemedicine	☐	☐	☐	☐	☒
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

- Cost of EHR vendor programs, enhancements and support.
- Cost of staff training.
- Cost of HIT support staff.
- Cost of new equipment.

81) How can Health Information Technology support Behavioral Health Integration?

- Enhance EHRs to seamlessly share a patient's health record.

- The Coalition has spent thousands of hours and dollars in customizing BH templates, workflows and administrative process to develop our EHR to support our integrated model of care. Perhaps incentives for software vendors to facilitate and develop integrated EHR programs is possible.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

- A bi-directional or some other electronic method to address incorrect information such as attribution.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

- Identify providers that are committed and competent to provide care to special needs populations.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

- Facilitate incentives for hospital participation.
- Affordability for providers to participate

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 039

Accepted by: KJDW

Notes: Standard cover sheet added; converted from PDF

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Alexis Weightman
Location: Denver, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Health Foundation
Location: Denver, Colorado

☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply: ☐ Client

☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
   i. Type or specialty: Click here to enter text.
   ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☒ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program? ☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☒ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Together with Rose Community Foundation, the Colorado Health Foundation is investing in an evaluation of the ACC that aims to help stakeholders:
-Understand the impact of the ACC on Medicaid beneficiaries
-Understand what aspects of the ACC are (or are not) effective -Inform future ACC policies
-Inform the content of future RFAs/RFPs -Provide evidence and analytic support to evaluate prospective policy options

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

We frequently interact with Medicaid as a key partner to help promote shared goals of advancing health care and coverage in the state of Colorado.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely

☐ Likely

☐ Reserved (waiting to see the RFP)

☐ Unlikely without significant changes

☐ Will not seek to participate

☒ N/A

Please feel welcome to describe why or why not using the space below.

Department of Health Care Policy and Financing
Attn: ACC Team 1570
Grant Street
Denver, CO 80203

Re: Accountable Care Collaborative Request for Information (RFI UHAA 2015000017)

Dear ACC team,

As an organization focused on making Colorado the healthiest state in the nation, we are writing to offer a few global considerations for the next phase of the Accountable Care Collaborative (ACC). The Colorado Health Foundation is a non-profit organization that engages through grantmaking, public policy, evaluation, private sector engagement and communications outreach. Our partners include nonprofits, health care leaders, policy makers, educators and the private sector. To achieve our vision, we focus on three community outcome areas: *Healthy Living*, *Health Coverage* and *Health Care* to ensure a future state where our communities promote health and our health care systems deliver excellent, affordable care to Coloradans who both have and desire good health. The ACC plays a critical role in helping us make progress on all our goals, and is directly aligned with our health care and health coverage work.

We strongly support the vision for the next Regional Care Collaborative Organization Request for Proposals that includes a focus on person-centered, integrated, coordinated supports and services and a transition from a medical model to a health model. In order for the ACC program to achieve this transformation, focus will need to be directed to prevention and health promotion, not just disease management. Additionally, we believe the integration of oral health care within primary care is an important component of a personcentered health model of service delivery. We encourage the Department to include the integration of oral health care in its efforts to improve the ACC program.

The Foundation applauds efforts by the Department to foster data-driven care improvements and decisionmaking through access to new technology platforms and other tools that provide actionable feedback and enable enhanced program monitoring, evaluation, and refinement. Health information technology in the ACC program should support the integration of physical and behavioral health care and the sharing of these data, as well as enhance connections to the community resources that make people healthier. Additionally, the Foundation supports the availability of shared intelligence engines, such as population health management, care management, and quality reporting/analytics solutions, that leverage existing statewide or regional IT infrastructure and data (e.g., CORHO, QHN) to achieve Triple Aim goals. We encourage the deployment of consumer-oriented solutions that empower individuals and families to manage and engage in their own health.

In partnership with the Rose Community Foundation, the Foundation is investing in an evaluation of the ACC that aims to help stakeholders:

- Understand the impact of the ACC on Medicaid beneficiaries
- Understand what aspects of the ACC are (or are not) effective
- Inform future ACC policies
- Inform the content of future RFAs/RFPs
- Provide evidence and analytic support to evaluate prospective policy options

Moving forward, we encourage rigorous, ongoing evaluation of the ACC's impacts on health outcomes as well as on Colorado's health care delivery system, including identifying the full benefits and costs of providing coordinated care to Medicaid enrollees.

The Foundation has been a proud partner with many organizations in projects that impact the care provided to Medicaid consumers, most of which in turn impact, and are impacted by, the ACC program. We have made investments that improve primary, behavioral, and oral health integration; provide increased capacity for person-centered medical homes, patient navigation and care coordination; and enhance consumer engagement and enrollment. Because of the lessons learned through these investments, we recognize that transformation will require a better understanding of the level of resources and coordination necessary to fully implement the ACC program. We strongly encourage the Department to seek and incorporate feedback from its stakeholders that will further the state's understanding of the resources and coordination required to achieve its vision of transformation.

In closing, we appreciate your efforts to build on the past successes of the ACC program to serve more people through greater efficiencies, payment reforms and improved quality of care. The focus on the health of the whole person and the whole family is essential. We are committed to supporting the ACC team through and beyond the development period by actively participating as engaged stakeholders. We greatly appreciate the efforts to incorporate client and stakeholder perspectives into the design of the future system and encourage the Department to maintain this consumer focus throughout the process. Please do not hesitate to contact Alexis Weightman, Policy Director at the Colorado Health Foundation at aweightman@coloradohealth.org or 303-953-3600 if you have any questions or we can be of assistance to you and your staff.

Thank you for the opportunity to provide input on this important development for the State of Colorado.

Sincerely,

Anne Warhover

Anne Warhover
President and CEO
The Colorado Health Foundation

Rahn Porter

Rahn Porter
Interim President and CEO
The Colorado Health Foundation

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 040

Accepted by: KJDW

Notes: Converted from PDF

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

Table of Contents

SECTION 1.0 OVERVIEW

1.1. PURPOSE OF THIS REQUEST FOR INFORMATION (RFI)

1.1.1. The Colorado Department of Health Care Policy and Financing (Department) is issuing this Request for Information (RFI) to solicit input on the next phase of the Accountable Care Collaborative (ACC).

1.1.2. Information provided to the Department in response to this Request for Information will inform the Department's Request for Proposals (RFP) for the Regional Care Collaborative Organizations (RCCO) and the future design of the ACC Program.

1.1.3. Anyone interested in responding is welcome to submit a reply (persons or entities responding to this RFI are called "respondents" throughout this document). The Department encourages everyone with ideas about the ACC to respond.

1.2. DEPARTMENT BACKGROUND

1.2.1. The Department serves as the Medicaid Single State Agency, as defined by Code of Federal Regulations (CFR) Title 45 Section 205.100 (45 CFR §205.100). The Department develops and implements policy and financing for Medicaid and the Children's Health Insurance Program, called Child Health Plan Plus (CHP+) in Colorado, as well as a variety of other publicly funded health care programs for Colorado's

low-income families, children, pregnant women, the elderly, and people with disabilities. For more information about the Department, visit www.Colorado.gov/HCPF.

1.3. PROGRAM BACKGROUND

1.3.1. The Accountable Care Collaborative (ACC) Program started in May 2011 with around 500 clients. Since that time, the ACC has grown in many ways. Today, the program covers over 700,000 people. The current phase of the ACC is focused on developing a strong network of contracted providers that can serve as medical homes for Medicaid clients. At the start of the program, enrollment was comprised largely of adults, and the pay-for-performance measures were designed for an adult population.

1.3.2. Over the course of the last three years, the ACC has expanded its focus from the medical home to the whole neighborhood of providers, such as specialists. Program enrollment expanded, increasing the number of children to mirror the overall Colorado Medicaid population. To continue developing the ACC, the Department updated pay-for-performance measures to include children and changed the payment model to support improved medical homes.

1.3.3. The ACC strives to provide the Colorado Medicaid program with a client and family-centered, whole-person approach that improves health outcomes and ensures savings. The program design includes a focus on clinically-effective and cost-effective utilization of services. The ACC works to identify the needs of clients and to use local resources to meet those needs.

1.3.4. The ACC was designed as a platform to transform the Colorado Medicaid program. The upcoming request for proposals (RFP) will build upon the successes of the current program by further developing the ACC to serve more people through greater efficiency and other incremental improvements. In addition to these updates to the program, this RFP will also seek to make bolder, more-comprehensive changes to the ACC through deeper integration, new payment reforms, and the promotion of whole-person/whole-family health.

1.3.5. These improvements will also be strengthened by significant investments in technology, as with the forthcoming Business Intelligence and Data Management (BIDM) system. These new platforms will allow for enhanced program monitoring and evaluation, and will give all parts of the ACC Program better data to improve care and decision-making.

1.3.6. As one of the major parts of the ACC, the RCCOs leverage local infrastructure, relationships, and community resources. The RCCOs' main responsibilities in the first RFP were:

1.3.6.1. Provider network development: developing a formal contracted network of primary care providers and an informal network of specialists and ancillary providers;

1.3.6.2. Care coordination: the RCCOs must ensure that every client has access to an appropriate level of medical management and care coordination;

1.3.6.3. Provider support: supporting providers in delivering efficient, high-quality care by offering clinical tools, client materials, administrative support, practice redesign, etc.; and

1.3.6.4. Accountability and reporting: the RCCOs are responsible for reporting to the Department on the region's progress, and meeting programmatic and Departmental goals.

1.3.7. The RCCOs are responsible for assisting clients with every aspect of their care. This means that they have to assist clients with their physical health and their behavioral health. The state pays providers directly for physical health services. In Colorado, Medicaid behavioral health services are managed by five Behavioral Health Organizations (BHOs) statewide. RCCOs frequently work with the BHOs to

coordinate care. Almost all Medicaid clients are enrolled in a BHO when they receive Medicaid. The BHOs get a set amount of money to manage the care for Medicaid clients, and the BHOs reimburse their network of providers for delivering services to those clients. The five regions that the BHOs manage do not match the regions managed by the RCCOs.

1.3.8. Today, there are seven RCCOs, each working in a specific part of Colorado. Each RCCO has adopted a different approach that works in its region. The RCCOs and their leadership play a vital role in the ACC and offer customized and local health care experience to the program. The ACC leverages personal, human connections to build on the strengths of local and regional partners.

1.3.9. Just as the first RCCO RFP initiated the ACC Program in Colorado, this second RFP will launch the next iteration of the ACC. What the program looks like in the future depends upon the RFP, and the content of the RFP depends upon the insight and guidance you offer through opportunities such as this Request for Information.

1.3.10. For more information on the ACC Program, click here

1.4. VISION FOR THE NEXT RCCO RFP

1.4.1. The next phase of the ACC Program will build on the strengths and the lessons learned during the first iteration. There are three main goals of the next RFP. The Department welcomes input on these goals and how to achieve them.

1.4.1.1. 1. Transforming our system from a medical model to a health model.

1.4.1.1.1. A person's health is impacted by his or her social situation (for example housing, income, transportation, nutrition, presence of supportive family and friends) as well as medical care. The next phase of the ACC Program aims to promote health by developing systems that support healthy lives, rather than just medical care.

1.4.1.2. 2. Moving toward person-centered, integrated, and coordinated supports and services.

1.4.1.2.1. Person-centered care means that the individual/family/caregiver is an equal participant with the provider in defining health goals and developing treatment plans. These both must address the whole person and be achievable within the context of the person's life. To accomplish this, RCCOs must also be able to coordinate more-closely with non-medical services and other state agencies. In order to do this, RCCOs must understand the community and culture where the person lives.

1.4.1.2.2. Part of a whole-person or person-centered approach is addressing both a person's physical and behavioral health needs in a way that is coordinated and cohesive, often referred to as integration. Taking steps towards integration or better coordination of physical and behavioral health care for Medicaid clients is a primary goal of the next RFP. Behavioral health care refers to all services to treat health conditions that primarily present as alterations in thinking, mood or behavior and changes in emotional (mood), psychological (thinking), or social well-being (behavior) and conditions related to addictions. To create the infrastructure for this integration, the Department seeks input on whether or how the Behavioral Health Organization (BHO) or RCCO maps or functions should be adjusted so that they are aligned.

1.4.1.2.3. This next RFP will aim to continue to build on local strengths of each community. This RFP aims to be sensitive to the diverse needs of clients with Medicaid coverage and will develop specific expectations around meeting the unique needs of subpopulations such as children, adults,

the elderly, persons with disabilities, clients involved in the criminal justice system, and all others.

1.4.1.2.4. Incorporating clients' perspectives is an ongoing process. The next RFP aims to strengthen opportunities for clients and advocates to provide input and play an important role in program design and ongoing improvement.

1.4.1.3. 3. Leveraging efficiencies to provide better quality care at lower costs to more people.

1.4.1.3.1. The next RFP aims to capture efficiencies and save money through enhanced technology and by supporting a diverse and changing health care workforce.

1.4.1.3.2. The RFP endeavors to align the financial drivers for all elements of the Medicaid delivery system. Through the RFP process, the Department will explore different ways to pay for care, bend the cost curve, and be as cost-effective as possible.

SECTION 2.0 ADMINISTRATIVE INFORMATION

2.1. RFI TERMS AND CONDITIONS

2.1.1. This RFI is issued solely for information and planning purposes and does not constitute a solicitation. Information about costs and pricing is submitted voluntarily and is non-binding on the respondent. Responses to this RFI will not be considered legal offers nor will they result in an award of any type of contract.

2.1.2. The Department is not responsible for any costs incurred by any respondents for the development and provision of a response to this RFI.

2.1.3. The Department is subject to strict accountability and reporting requirements as a recipient of funds from public sources. Responses to this RFI are subject to disclosure by the Department as required by the Colorado Open Records Act (CORA). The Department plans to make responses to this RFI available for review online.

2.1.4. The Department reserves the right to copy any information provided by respondents for the purposes of facilitating the Department's review of / use of the information.

2.1.5. The Department reserves the right to use information or ideas that are provided by respondents. By submitting information in response to this RFI, the entity or individual represents that such copying or use of information will not violate any copyrights, licenses, or other agreements with respect to information submitted.

2.1.S.1. The responses received from this RFI may be used for the development of a future solicitation. Should a solicitation be issued, further details on the solicitation process will be provided.

2.2. POINT OF CONTACT

2.2.1. The Department's point of contact for this RFI is:

2.2.1.1. Kevin Dunlevy-Wilson (note: other Department staff may address e-mails or phone calls)

2.2.1.2. Department of Health Care Policy and Financing

2.2.1.3. Accountable Care Collaborative Strategy Unit

2.2.1.4. 1570 Grant Street

2.2.1.5. Denver, CO 80203-1818

2.2.1.6. Phone: 303-866-5351

2.2.1.7. RCCORFP@state.co.us

2.3. NOTICES AND COMMUNICATIONS

2.3.1. Communication with respondents will be via various methods including, but not limited to, e-mail, phone, mail, the Department's ACC RFP Web site at: https://www.colorado.gov/pacific/hcpf/regional-care-collaborative-organizations-rccos-requestproposals-rfp and notices on the CORE Web site at: https://codpa-vss.hostams.com/webapp/PRDVSS1X1/AltSelfService;jsessionid=00007DXSIavpsnQoNcRwuPiYmie:189n1g4b1. Respondents can view information posted on CORE by clicking on the "Public Access" button. It is the respondent's responsibility to periodically check the Colorado CORE Web site or the ACC RFP Web site for notices, changes, additional documents or amendments that pertain to this RFI.

2.4. TIMELINE

2.4.1. The timeline for this RFI is as follows:

ACTIVITY	DATE
RFI RELEASE DATE	OCTOBER 21, 2014
INQUIRIES REGARDING THE RFI ACCEPTED UNTIL	OCTOBER 31, 2014 11:00 AM MOUNTAIN TIME
DEPARTMENT RESPONSES TO RFI INQUIRIES (ESTIMATED)	NOVEMBER 10, 2014
RFI RESPONSE SUBMISSION DUE DATE	NOVEMBER 24, 2014 3:00 PM MOUNTAIN TIME

SECTION 3.0 RESPONSES

3.1. INQUIRIES

3.1.1. For inquiries about this RFI, you may send an email to: RCCORFP@state.co.us. If preferred, you may also contact the ACC RFP team by phone at: 303-866-5351. Include the RFI number and title listed in the e-mail subject line.

3.1.1.1. The Department will track the questions that it receives and aggregate the questions into an "Inquiries and Answers" document.

3.1.2. Inquiries received by the Department by the Inquiry Deadline will be responded to by the Department via a posting of the "Inquiries and Answers" document on the CORE Web site and the ACC RFP Web site. Inquiries received after the Inquiry Deadline may not be included in the Department's response.

3.2. PROTECTED HEALTH INFORMATION

3.2.1. Do not include Protected Health Information (PHI) in your response.

3.2.2. If the Department discloses the responses online or via a CORA request, unless the responder explicitly requested otherwise, responses by all Medicaid clients will be identified only by first initial and county of residence. Example: John Doe would be listed as: "'J.' Weld County." Requests for pseudonyms will generally be granted if requested.

3.3. RESPONSE FORMAT

3.3.1. The RFI is broken into the following sections:

3.3.1.1. Basic information about you, the respondent.

3.3.1.2. General Questions

3.3.1.3. Behavioral Health Integration

3.3.1.4. Care Coordination

3.3.1.5. Program Structure

3.3.1.6. Stakeholder Engagement

3.3.1.7. Network Adequacy and Creating a Comprehensive System of Care

3.3.1.8. Practice Support

3.3.1.9. Payment Structure and Quality Monitoring

3.3.1.10. Health Information Technology

3.3.2. The Department is requesting respondents to send any comments or answers, no matter how minor, to the Department. Respondents are encouraged to address the questions listed in the Response Worksheet, but you do not have to reply to all of the questions in a section.

3.3.3. Please note that early responses are appreciated. Respondents do not need to wait until SUBMISSION DATE (see Section 2.4) to submit comments. The Department appreciates receiving any and all comments from respondents.

3.3.4. Reponses should be emailed to RCCORFP@state.co.us. Your answers may be submitted as an attachment or an email. If they cannot be emailed, they may also be sent, in hard copy, to: Colorado Department of Health Care Policy and Financing, Attention: ACC Team, 1570 Grant St., Denver, CO 80203. Following receipt of your response, you should receive a confirmation email within three (3) business days.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Coral Cosway

Location: 1580 Logan St., Ste. 400, Denver CO 80203

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Behavioral Healthcare Council

Location: 1580 Logan St., Ste. 400, Denver, CO 80203

☒Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply: ☐Client

☐Client's family member

☐Client advocate

☐Medical provider / PCMP / other provider

i. Type or specialty: Click here to enter text.

ii. Area of practice: Click here to enter text.

☒Provider advocate (e.g. medical society)

☐Potential bidder for RCCO contract

☐Behavioral Health Organization

☐Data or HIT entity

☐Foundation

☐Educational or research institution

☐Another public or private program

☐Legislator or elected official

☐Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☐Yes

☒No

☐ don't know

If you answered "yes" above, how long?

☐Less than one year

☐1-2 years

☐2-3 years

How have you been involved in the ACC program and what interaction have you had with RCCOs: Our BHO members coordinate with the RCCOs in their regions.

Please briefly describe your involvement with Medicaid, either in Colorado or another state: We represent organizations that are Medicaid providers or are managing service delivery to Medicaid enrollees. This includes Colorado's 17 Community Mental Health Centers, 5 Behavioral Health Organizations, 4 Managed Service Organizations, and 2 Specialty Clinics.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐Very likely

☐Likely

☐Reserved (waiting to see the RFP)

☐Unlikely without significant changes

☐Will not seek to participate

☒N/A

Our members have already taken significant steps to integrate their behavioral health services with physical health services for the benefit of all their clients/patients, including the Medicaid enrollees they serve. We hope the RFP will encourage and

enable an even higher level of integration. Our members look forward to being an integral part of moving that integrated system forward in Colorado.

☐3-4 years

☐Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

   No answer

2) What is not working well in the ACC Program?

   No answer

3) What is working best in the Behavioral Health Organization (BHO) system right now?

   The existing risk-based payment model has enabled the BHOs and their extensive network of community partners to create a person-focused, integrated healthcare delivery system that is tailored to the needs of the communities they serve. By "integrated" we mean a system that provides behavioral, physical and human services as needed to improve health outcomes. This innovative system is able to provide the right services, at the right place, at the right time to achieve the triple aim (e.g., improved population health outcomes, improved client/patient experience, and reduced per capita healthcare costs) with respect to behavioral healthcare needs.

   It should be noted that neither a total "carve-in" or "carve-out" of behavioral healthcare services will enable achievement of the triple aim. Some middle path is required that allows for coordination, local flexibility, and separation as needed to operationalize integrated care in the context of the current regulatory environment and financing systems. The 1915(b)(3) Managed Care Waiver has allowed the BHOs to bend the cost curve and must be kept in place as the State contemplates how it will bring together physical and behavioral healthcare in the future in a manner that maintains the most effective parts of each system. The RCCO RFP should reward bidders who can integrate care, data, and financing.

   Additionally, having a system able to manage and pay for the care of people with significant and complex health needs, as behavioral health has been able to do, will be critical if the State plans to expand the Medicaid behavioral health benefit to populations such as people with developmental disabilities, autism, and traumatic brain injury.

4) What is not working well in the BHO system?

   Colorado's behavioral healthcare system is currently experiencing workforce shortage issues that are making it difficult to attract enough behavioral healthcare professionals to Colorado to meet the

increasing demand for services. Some barriers to hiring new staff include long wait times for licensure approval within the Colorado Department of Regulatory Affairs (DORA), reimbursement rates that don't allow for the ability to substantially increase pay for these professionals, and limits in loan repayment program capacity.

State data system problems are also significant barriers to BHO operations. The State's current data system forces BHO staff to spend a significant amount of time focused on data reporting and sharing (much larger than would be the case with a sufficient data system). Also, the lack of real-time physical health data because of limitations of the State's data system prevents the BHOs from being able to change the course of a client's care during a health event. Also, the system's inability to hold data on a patient's substance use disorder issues prevents the RCCOs from understanding the complete health needs of their patients.

Existing government funding streams for behavioral health (Medicaid and OBH dollars) are in silos that aren't easily aligned by either providers or the State. These funds should work together to support comprehensive care and population health objectives.

5) What is working well with RCCO and BHO collaboration right now?

No answer

6) What is not working well with RCCO and BHO collaboration right now? No answer

Behavioral Health Integration

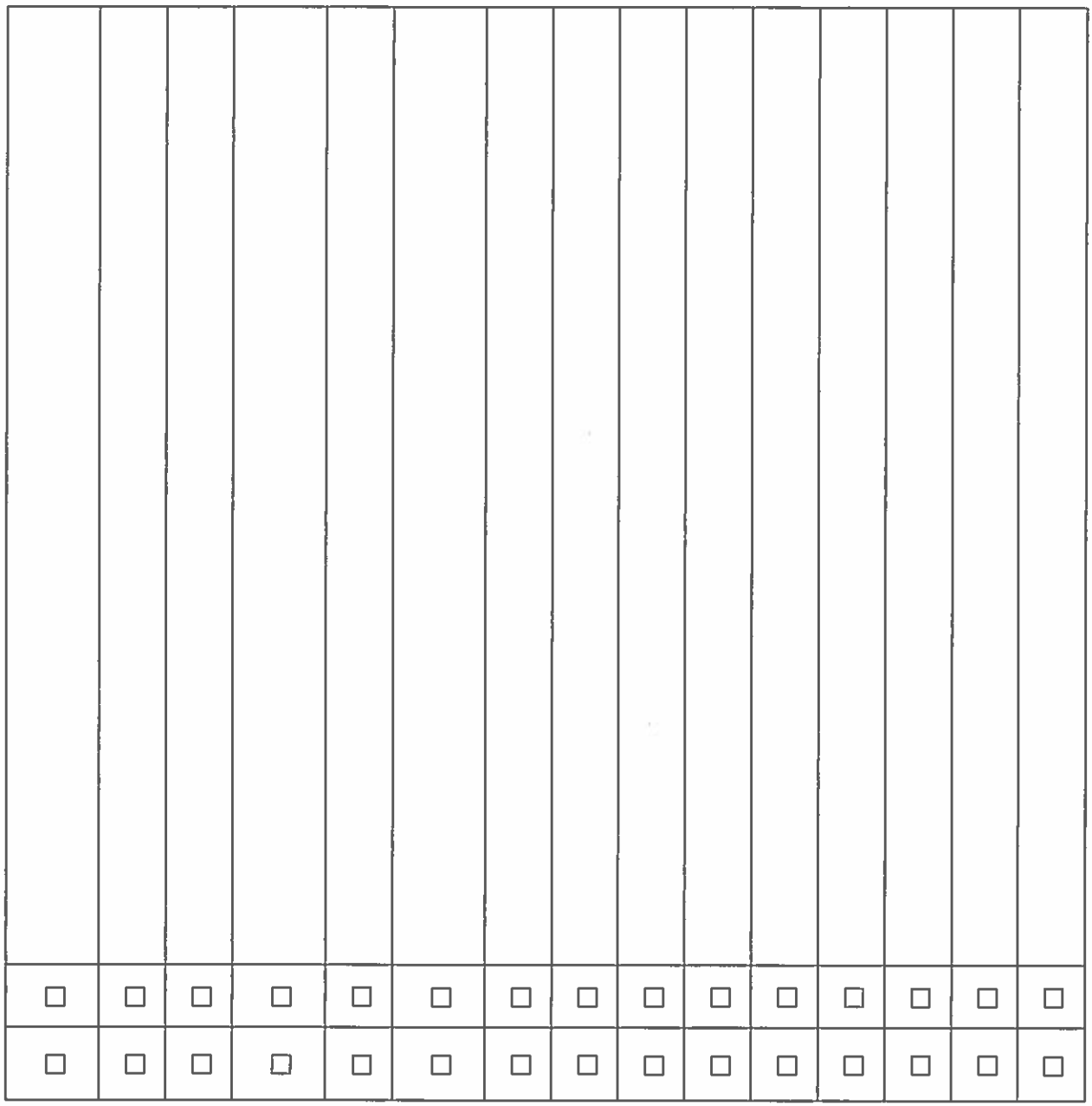
7) What should be the next steps in behavioral health integration in Colorado?[1]

Healthcare integration should align in the RCCO, BHO, and commercial insurance environments in order to achieve the goals of Colorado's State Health Innovation Plan. This should involve administrative systems, financing, data, the needs of clients/patients (including medical, behavioral and human services), and provider needs. Attention should also be paid to the amount of regulatory burden and payment structures in the overall system. Efforts should be made to streamline reporting and other regulatory requirements as much as possible while still maintaining the oversight needed to ensure improved health outcomes. Payment systems should support integration and whole-person care.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) Barriers to the integration of behavioral health and physical health services. Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:



Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	Please type your response here.		

Covered diagnoses list

Different behavioral / physical health reimbursement

Institutions for Mental Diseases exclusion

OBH rules, reporting, or financing (regulatory differences between agencies)

PCMP financing structure

Per-member per-month amount

Physical space constraints

Privacy Laws (HIPAA, 42 CFR)

Professional / cultural divisions

RCCO or BHO contracts

Staff capacity

State/Federal rules or reporting requirements

Technical resources / data sharing

Training

Others

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, wholeperson/whole-family physical and behavioral health care?

The Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions has developed a framework for levels of healthcare integration. This framework outlines key elements necessary for each level of integration, including[1]:

Level 1, Minimal Collaboration

- Located in separate facilities
- Separate systems
- Communication is minimal and driven by provider need in compelling cases only (may never meet in person)
- Limited understanding of each other's roles

Level 2, Basic Collaboration at a Distance

- Located in separate facilities
- Separate systems
- Communicate periodically about shared projects (communication driven by specific patient issues)
- Meet as part of a larger community
- Appreciate each other's roles as resources

Level 3, Basic Collaboration Onsite

- In the same facility but not necessarily in the same offices
- Separate systems
- Communication is regular about shared clients/patients using phone or email
- Collaborate based on need for each other's services and referrals
- Meet occasionally to discuss specific cases
- Feel part of a larger, yet ill-defined team

Level 4, Close Collaboration Onsite with Some System Integration

- In the same space within the same facility
- Share some systems (e.g., scheduling or medical records)
- Communication is in person as needed (have regular face-to-face interactions about some clients/patients)
- Collaborate based on needs of difficult clients/patients
- Have a basic understanding about roles and cultures

Level 5, Close Collaboration Approaching an Integrated Practice

- In the same space within the same facility with some shared space
- Actively seek system solutions or work-a-rounds together
- Communicate frequently in person
- Collaboration is driven by a desire to be a member of a care team
- Regular meetings to discuss overall client/patient care and specific client/patient issues
- Have an in-depth understanding of roles and cultures

Level 6, Full Collaboration in a Transformed/Merged Integrated Practice

- In the same space within the same facility sharing all practice space
- Have resolved most or all system issues and are functioning as one integrated system
- Communicate consistently at the system, care team, and individual levels
- Collaboration is driven by a shared concept of team care
- Have formal and informal meetings to support the existing integrated model of care • Have roles and cultures that blur or blend

[1] Heath B, Wise Romero P, and Reynolds K. A review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, DC. SAMHSA-HRSA Center for Integrated Health Solutions. March 2013.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Moving toward an integrated system of healthcare is a process. All practices should start at the level of integration (see model noted in question #9) that their community resources and partnerships allow. Then they should develop a strategic plan to move toward higher levels of integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

No answer

b. How should RCCOs prioritize who receives care coordination first?

No answer

c. How should RCCOs identify clients and families who need care coordination?

No answer

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

RCCOs should develop a system that utilizes as much of the existing data reporting processes for that provider type as possible to reduce additional administrative burdens on providers.

12) What services should be coordinated and are there services that should not be a part of care coordination?

No answer

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

No answer

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

No answer

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

Because behavioral healthcare sometimes includes a human services component (i.e., wrap-around services), these providers are already coordinating this care for their clients. The purpose of this care coordination is to obtain the services that the client needs in order for their mental health or substance use disorder (SUD) treatment to be effective. Behavioral health providers are also currently coordinating care between mental health and SUD services.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

Place the care coordination relationship where it makes the most sense for the client/patient based on their physical and behavioral health needs. A patient with only medical needs may be best served by the RCCO or a physical health provider. However, a client/patient with a mental health and/or SUD issue may be better served with their care coordination placed with the behavioral health entity providing those services. This is especially true if the client/patient requires human (wrap-around) services as well.

d. What are the gaps in care coordination across the continuum of care?

No answer

15) RCCOs' roles in addressing clients' and their families' non-medical needs. Please complete the table below, keeping in mind adults, children, and families:

	Should the RCCO have a role?		Should the RCCOs coordinate with community supports and services?	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Non-medical need:	Yes	No	Yes	

Abuse, neglect, and trauma	☐	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	
Health literacy	☐	☐	☐	
Housing	☐	☐	☐	
Language or translation services	☐	☐	☐	
Literacy				
Transportation	☐	☐	☐	
Other	☐	☐	☐	

RCCOs should be expected to continue to coordinate with the BHOs to ensure their patients are receiving needed services for behavioral health issues.

16) Requirements about who should be doing care coordination. Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care?	In what capacity should these individuals coordinate care in the ACC Program?

☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
Yes	No	

Advanced Practice (Registered) Nurses

Certified Addiction Councilors

Certified Nurse Midwives

Community Health Workers

Generalists (BA/BS/MA/MS)

Health Coaches

Licensed Clinical Social Workers

Licensed Marriage and Family Therapist

Licensed Mental Health Counselors

Licensed Professional Counselor

Masters of Public Health

Medical Doctors / Doctors of Osteopathic Medicine

Nurse Practitioners

Patient Navigators

Peer Advocates

Promotoras

Psychiatrists

Psychologists

Registered Nurses

Social Workers

Wraparound facilitators

Other

☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	

Care coordination should be placed with the provider most appropriate for that client/patient.

17) Care coordination requirements for specific populations. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	

Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

No answer

19) How should care coordination be evaluated? How should its outcomes be measured?

No answer

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

No answer

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

No answer

a. Care coordinator to client ratios. If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
S1-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

No answer

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Care coordination efforts should align with Section 2703 of the Affordable Care Act for clients/patients with multiple chronic health conditions.

Be careful not to over-regulate care coordination. Allow flexibility to determine what works best for clients/patients. The goal should be better health outcomes, not creating another care plan for the sake of 'checking a box' on a form.

Care coordination is most effective when it's done at the point of care.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

As much as possible, regulatory activities should be streamlined while allowing enough local flexibility to enable the RCCO and contracted providers to achieve the triple aim in the communities they serve.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

No answer

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

No answer

27) Should the RCCO region maps change? Why or why not? If so, how?

Changes to the RCCO map should be informed by existing data. Boundaries should reflect how patients access care to ensure the best health outcomes.

28) Should the BHO region maps change? Why or why not? If so, how?

No answer

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition? No answer

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

No answer

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

Continuous eligibility is integral to ensuring continuity of care; achieving improved health outcomes; and reducing long-term costs.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

No answer

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

No answer

34) What role should RCCOs play in attributing clients to their respective PCMPs?

Clients/patients should be attributed to a PCMP that can best meet their needs and can serve them in their community.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

No answer

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

Providing appropriate human services (i.e., wrap-around services) along with healthcare services can be an integral part of making and keeping a client healthy. The value of these services to improving health outcomes and reducing future healthcare costs should not be overlooked. Funding sources for these services (in HCPF and OBH) should work together to support comprehensive healthcare for Coloradans.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

No answer

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

The ACC Program should work with DORA to develop a specific license for integrated care practices. This license should streamline regulatory processes and requirements between the two existing systems (physical and behavioral health).

Also, the ACC Program should work with DORA to modify licensure processes that currently slow the movement of qualified licensed healthcare professionals to Colorado from other states.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

No answer

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

No answer

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

No answer

42) How should the Department structure stakeholder engagement for the ACC as a whole? No answer

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

There is currently a shortage of behavioral health practitioners in Colorado, including psychiatrists (especially those who treat children), mid-level practitioners and those with prescriptive authority. The ACC Program should work with DORA to reduce the regulatory burdens associated with qualified practitioners becoming licensed in Colorado. The State should support expanded scopes of practice where appropriate for mid-level practitioners. Also, bidders should be rewarded for investments in telehealth that could help ease this workforce shortage.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past? No answer

45) How can RCCOs help to support clients and families in making and keeping appointments?

The Community Mental Health Centers (CMHCs) have adapted their appointment procedures based on observed client behaviors to identify what procedures are most effective at getting clients to make and keep appointments. The RCCOs can learn from the CMHC's experience and facilitate the dissemination of that knowledge to their contracted providers.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

No answer

47) Community Health Worker reimbursement. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐

On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

No answer

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Bidders should be expected to demonstrate that they, or their community partners, can provide services in a culturally-competent manner.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

No answer

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

The ACC Program should develop a way for RCCOs to share more real-time data with providers so they can intervene while the client/patient is still in the emergency room.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

No answer

Practice Support

53) Support for practices. Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Should a specific tool be required? Yes	No	Should the state
	☐	☐	☐
efficiency-enhancing activities -based	☐	☐	☐
resources and directories	☐	☐	☐
-specific data reports	☐	☐	☐
:linical care guidelines and best practices.	☐	☐	☐
screening tools	☐	☐	☐
ıealth and functioning questionnaires	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
-management tools	☐	☐	☐
ıcational materials about specific conditions	☐	☐	☐
	☐	☐	☐
-screening tools	☐	☐	☐
	☐	☐	☐
other self-screening tools	☐	☐	☐
	☐	☐	☐
-competent care	☐	☐	☐
	☐	☐	☐
interviewing	☐	☐	☐
ools and software for phone call and appointment tracking	☐	☐	☐
ools and resources for tracking labs, referrals, etc. Provide	☐	☐	☐
ınd transitions of care checklists	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
:omprehensive directory of community resources	☐	☐	☐
	☐	☐	☐
naterials regarding Nurse Advice Line	☐	☐	☐
ll tools and resources are centrally located on RCCO-	☐	☐	☐
	☐	☐	☐

☐	☐	☐	☐
☐	☐	☐	☐
☐	☐	☐	☐

provide?

Administrative support
Network provider education
Assistance with practice redesign
Assistance with
Provide web
Provide practice

Provide clinical

Provide chronic care templates
Provide registries
Offer client reminders
Offer client self

Supply behavioral health surveys
Supply other self
Administer behavioral health surveys
Administer
Prepare client action plans
Provide training on providing culturally
Provide training to supporting staff
Provide training on motivational

Provide visit agendas or templates
Provide standing pharmacy order templates

Provide directory of other resources
Provide

specific website

Others

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

No answer

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

No answer

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

Incentivize providers to manage and carry risk. Withholding part of an existing contract amount is not an incentive program. A true incentive program provides dollars above a contract amount for achieving goals.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population? No answer

58) Please share any other advice or suggestions about provider support in the ACC. No answer

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

The ACC Program should consider moving toward a model where the RCCOs assume and manage risk.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

CBHC members are succeeding under a risk-based (capitated) system in ways that wouldn't be possible under a fee-for-service system. The capitated system allows for more flexibility to provide the right services at the right place at the right time to meet the triple aim.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Yes, however, value must be measured appropriately – meaning that the items being measured are statistically valid, impact either the quality of care or outcomes, and are elements the provider can influence. Accountability measures need to focus on health outcomes instead of services delivered.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding? No answer

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

No answer

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

No answer

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes? No answer

66) Measuring Client experience. Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used?	Comments:

☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	

Please type your response here.

Yes No

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

SF-12 Health Survey

Other types of client interviews / surveys

Patient Activation Measure

Focus groups

Other

67) Knowing that, at this time, the Department only has claims data, how should population health be measured? No answer

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

No answer

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐

8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

No answer

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Use national standards as a baseline and incentivize improvement within reasonable boundaries.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

No answer

74) Incentive payment frequency. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐

Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

No answer

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

No answer

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Managed care organizations, such as the BHOs, have these measures, such as access to care measurements, in their contracts.

Health Information Technology (HIT)

77) Types of communication. For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) HIT investments by organizations. For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐

Other:	☐	☐

79) Importance of technology by type. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-S, where 1 are those items least-likely to be used, and S are items most-likely to be used:

Tool	1 Least	2	3	4	S Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☐
Care management tool	☐	☐	☐	☐	☐
Care transitions alerts	☐	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☐
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

No answer

81) How can Health Information Technology support Behavioral Health Integration?

The ACC Program should look for bidders willing to invest in technology that fosters integration and can overcome the challenges of the State's data system.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

Whatever platform is created, it should be able to include behavioral health data (including substance use disorder information) as well as physical health data.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

No answer

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

No answer

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

To reduce the stigma of behavioral health services and move toward integrated care on the client/patient side (not just the provider side), a provider directory would need contain both physical and behavioral health providers.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

Allow the RCCOs to share data outside the existing state data system with provider entities as needed to enable the use of timely clinical data to improve care.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

No answer

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

No answer

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

It's essential that exchange platforms are available to both physical and behavioral health providers. Also, it's critical that the platforms allow for the easy exchange of information, including real-time data that can be used to change the course of a client/patient's treatment.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

No answer

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 041

Accepted by: KJDW

Notes: Standard cover sheet added; consolidated to single file

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Colorado Chapter

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November 19, 2014

Dr. Judy Zerzan (or appropriate HCPF executive)
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Dr. Zerzan,
One behalf of the Colorado Chapter of the American Academy of Pediatrics (CO-AAP), and its over 500 (?) pediatricians across Colorado, we respectfully submit the follow comments in response to the Accountable Care Collaborative (ACC) Request for Information.

Over the course of the past several years, members of the CO-AAP have been involved in various aspects of the ACC and RCCO rollout. The Chapter has publically pledged support for the important initiative, and has worked diligently with the Department to collaboratively integrate pediatric practices into the RCCO model. Additionally, Chapter members have served and continue to serve in a variety of advisory capacities for the RCCOs and several internal Department committees.

It is with this spirit of collaboration that we submit the attached RFI answers on behalf of the Chapter. The recommendations have been developed in conjunction with the Colorado Children's Health Care Access Program and many community pediatricians.

We look forward to beginning a dialog with your team about the next steps for the state's ACC program, while keeping our focus on serving children and families at the forefront. Please feel free to contact me with any questions, and I look forward to discussing with you soon.

Regards,

Joe Craig, MD, FAAP
President, American Academy of Pediatrics, Colorado Chapter

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name:

Location:

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization:

Location:

☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty:
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Click here to enter text.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

Are you currently involved in the ACC program?

☐ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.

- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings;

unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.

- So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
- Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
- There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and

"medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing 5DAC data is just one way to understand the activities within a medical home. SDAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients
  b. Telephone consultation by a child psychiatrist to primary care providers

We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Care Coordination

Question 12) What needs for children/families should be coordinated in medical homes and are there services that should not be a part of care coordination by the pediatric and family medical home

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Our medical home relates to multiple RCCOs and we want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we could receive a pmpm from all of them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where should care coordination be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good

care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill? The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They

should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County
- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to

receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

- Since children are the majority and give the best chance of truly improving health and wellness, KPIs need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully. Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and provider from medical homes to develop a vetting process that will enable HCPF and RCCOs to trust medical home self-reported real-time data.

- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd. Appropriate child health measures could be selected from the following measures :
    - Well child visits appropriate for age
    - Developmental screening by three years of age
    - Teen depression screening
    - Complete immunization status by age two
    - Post-partum depression screening rate for mothers of newborns by age 4 months
    - Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
    - Patient (or family) satisfaction ratings
    - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 042

Accepted by: KJDW

Notes: Standard cover sheet added;

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

Table of Contents

SECTION 1.0 OVERVIEW

1.1. PURPOSE OF THIS REQUEST FOR INFORMATION (RFI)

1.1.1. The Colorado Department of Health Care Policy and Financing (Department) is issuing this Request for Information (RFI) to solicit input on the next phase of the Accountable Care Collaborative (ACC).

1.1.2. Information provided to the Department in response to this Request for Information will inform the Department's Request for Proposals (RFP) for the Regional Care Collaborative Organizations (RCCO) and the future design of the ACC Program.

1.1.3. Anyone interested in responding is welcome to submit a reply (persons or entities responding to this RFI are called "respondents" throughout this document). The Department encourages everyone with ideas about the ACC to respond.

1.2. DEPARTMENT BACKGROUND

1.2.1. The Department serves as the Medicaid Single State Agency, as defined by Code of Federal Regulations (CFR) Title 45 Section 205.100 (45 CFR §205.100). The Department develops and implements policy and financing for Medicaid and the Children's Health Insurance Program, called Child Health Plan Plus (CHP+) in Colorado, as well as a variety of other publicly funded health care programs for Colorado's low-income families, children, pregnant women, the elderly, and people with disabilities. For more information about the Department, visit www.Colorado.gov/HCPF.

1.3. PROGRAM BACKGROUND

1.3.1. The Accountable Care Collaborative (ACC) Program started in May 2011 with around 500 clients. Since that time, the ACC has grown in many ways. Today, the program covers over 700,000 people. The current phase of the ACC is focused on developing a strong network of contracted providers that can serve as medical homes for Medicaid clients. At the start of the program, enrollment was comprised largely of adults, and the pay-for-performance measures were designed for an adult population.

1.3.2. Over the course of the last three years, the ACC has expanded its focus from the medical home to the whole neighborhood of providers, such as specialists. Program enrollment expanded, increasing the number of children to mirror the overall Colorado Medicaid population. To continue developing the ACC, the Department updated pay-for-performance measures to include children and changed the payment model to support improved medical homes.

1.3.3. The ACC strives to provide the Colorado Medicaid program with a client and family-centered, whole-person approach that improves health outcomes and ensures savings. The program design includes a focus on clinically-effective and cost-effective utilization of services. The ACC works to identify the needs of clients and to use local resources to meet those needs.

1.3.4. The ACC was designed as a platform to transform the Colorado Medicaid program. The upcoming request for proposals (RFP) will build upon the successes of the current program by further developing the ACC to serve more people through greater efficiency and other incremental improvements. In addition to these updates to the program, this RFP will also seek to make bolder, more-comprehensive changes to the ACC through deeper integration, new payment reforms, and the promotion of whole-person/whole-family health.

1.3.5. These improvements will also be strengthened by significant investments in technology, as with the forthcoming Business Intelligence and Data Management (BIDM) system. These new platforms will allow for enhanced program monitoring and evaluation, and will give all parts of the ACC Program better data to improve care and decision-making.

1.3.6. As one of the major parts of the ACC, the RCCOs leverage local infrastructure, relationships, and community resources. The RCCOs' main responsibilities in the first RFP were:

1.3.6.1. Provider network development: developing a formal contracted network of primary care providers and an informal network of specialists and ancillary providers;

1.3.6.2. Care coordination: the RCCOs must ensure that every client has access to an appropriate level of medical management and care coordination;

1.3.6.3. Provider support: supporting providers in delivering efficient, high-quality care by offering clinical tools, client materials, administrative support, practice redesign, etc.; and

1.3.6.4. Accountability and reporting: the RCCOs are responsible for reporting to the Department on the region's progress, and meeting programmatic and Departmental goals.

1.3.7. The RCCOs are responsible for assisting clients with every aspect of their care. This means that they have to assist clients with their physical health and their behavioral health. The state pays providers directly for physical health services. In Colorado, Medicaid behavioral health services are managed by five Behavioral Health Organizations (BHOs) statewide. RCCOs frequently work with the BHOs to coordinate care. Almost all Medicaid clients are enrolled in a BHO when they receive Medicaid. The BHOs get a set amount of money to manage the care for Medicaid clients, and the BHOs reimburse their network of providers for delivering services to those clients. The five regions that the BHOs manage do not match the regions managed by the RCCOs.

1.3.8. Today, there are seven RCCOs, each working in a specific part of Colorado. Each RCCO has adopted a different approach that works in its region. The RCCOs and their leadership play a vital role in the ACC and offer customized and local health care experience to the program. The ACC leverages personal, human connections to build on the strengths of local and regional partners.

1.3.9. Just as the first RCCO RFP initiated the ACC Program in Colorado, this second RFP will launch the next iteration of the ACC. What the program looks like in the future depends upon the RFP, and the content of the RFP depends upon the insight and guidance you offer through opportunities such as this Request for Information.

1.3.10. **For more information on the ACC Program, click here**

1.4. VISION FOR THE NEXT RCCO RFP

1.4.1. The next phase of the ACC Program will build on the strengths and the lessons learned during the first iteration. There are three main goals of the next RFP. The Department welcomes input on these goals and how to achieve them.

1.4.1.1. 1. Transforming our system from a medical model to a health model.

1.4.1.1.1. A person's health is impacted by his or her social situation (for example housing, income, transportation, nutrition, presence of supportive family and friends) as well as medical care. The next phase of the ACC Program aims to promote health by developing systems that support healthy lives, rather than just medical care.

1.4.1.2. 2. Moving toward person-centered, integrated, and coordinated supports and services.

1.4.1.2.1. Person-centered care means that the individual/family/caregiver is an equal participant with the provider in defining health goals and developing treatment plans. These both must address the whole person and be achievable within the context of the person's life. To accomplish this, RCCOs must also be able to coordinate more-closely with non-medical services and other state agencies. In order to do this, RCCOs must understand the community and culture where the person lives.

1.4.1.2.2. Part of a whole-person or person-centered approach is addressing both a person's physical and behavioral health needs in a way that is coordinated and cohesive, often referred to as integration. Taking steps towards integration or better coordination of physical and behavioral health care for Medicaid clients is a primary goal of the next RFP. Behavioral health care refers to all services to treat health conditions that primarily present as alterations in thinking, mood or behavior and changes in emotional (mood), psychological (thinking), or social well-being (behavior) and conditions related to addictions. To create the infrastructure for this integration, the Department seeks input on whether or how the Behavioral Health Organization (BHO) or RCCO maps or functions should be adjusted so that they are aligned.

1.4.1.2.3. This next RFP will aim to continue to build on local strengths of each community. This RFP aims to be sensitive to the diverse needs of clients with Medicaid coverage and will develop specific expectations around meeting the unique needs of subpopulations such as children, adults, the elderly, persons with disabilities, clients involved in the criminal justice system, and all others.

1.4.1.2.4. Incorporating clients' perspectives is an ongoing process. The next RFP aims to strengthen opportunities for clients and advocates to provide input and play an important role in program design and ongoing improvement.

1.4.1.3. 3. Leveraging efficiencies to provide better quality care at lower costs to more people.

1.4.1.3.1. The next RFP aims to capture efficiencies and save money through enhanced technology and by supporting a diverse and changing health care workforce.

1.4.1.3.2. The RFP endeavors to align the financial drivers for all elements of the Medicaid delivery system. Through the RFP process, the Department will explore different ways to pay for care, bend the cost curve, and be as cost-effective as possible.

SECTION 2.0 ADMINISTRATIVE INFORMATION

2.1. RFI TERMS AND CONDITIONS

2.1.1. This RFI is issued solely for information and planning purposes and does not constitute a solicitation. Information about costs and pricing is submitted voluntarily and is non-binding on the respondent. Responses to this RFI will not be considered legal offers nor will they result in an award of any type of contract.

2.1.2. The Department is not responsible for any costs incurred by any respondents for the development and provision of a response to this RFI.

2.1.3. The Department is subject to strict accountability and reporting requirements as a recipient of funds from public sources. Responses to this RFI are subject to disclosure by the Department as required by the Colorado Open Records Act (CORA). The Department plans to make responses to this RFI available for review online.

2.1.4. The Department reserves the right to copy any information provided by respondents for the purposes of facilitating the Department's review of / use of the information.

2.1.5. The Department reserves the right to use information or ideas that are provided by respondents. By submitting information in response to this RFI, the entity or individual represents that such copying or use of information will not violate any copyrights, licenses, or other agreements with respect to information submitted.

2.1.5.1. The responses received from this RFI may be used for the development of a future solicitation. Should a solicitation be issued, further details on the solicitation process will be provided.

2.2. POINT OF CONTACT

2.2.1. The Department's point of contact for this RFI is:

2.2.1.1. Kevin Dunlevy-Wilson (note: other Department staff may address e-mails or phone calls)

2.2.1.2. Department of Health Care Policy and Financing

2.2.1.3. Accountable Care Collaborative Strategy Unit

2.2.1.4. 1570 Grant Street

2.2.1.5. Denver, CO 80203-1818

2.2.1.6. Phone: 303-866-5351

2.2.1.7. RCCORFP@state.co.us

2.3. NOTICES AND COMMUNICATIONS

2.3.1. Communication with respondents will be via various methods including, but not limited to, e-mail, phone, mail, the Department's ACC RFP Web site at: https://www.colorado.gov/pacific/hcpf/regional-care-collaborative-organizations-rccos-request-proposals-rfp and notices on the CORE Web site at: https://codpa-vss.hostams.com/webapp/PRDVSS1X1/AltSelfService;jsessionid=00007DX5IavpsnQoNcRwuPiYmie:189n1q4b1. Respondents can view information posted on CORE by clicking on the "Public Access" button. It is the respondent's responsibility to periodically check the Colorado CORE Web site or the ACC RFP Web site for notices, changes, additional documents or amendments that pertain to this RFI.

2.4. TIMELINE

2.4.1. The timeline for this RFI is as follows:

ACTIVITY	DATE
RFI RELEASE DATE	OCTOBER 21, 2014
INQUIRIES REGARDING THE RFI ACCEPTED UNTIL	OCTOBER 31, 2014 11:00 AM MOUNTAIN TIME
DEPARTMENT RESPONSES TO RFI INQUIRIES (ESTIMATED)	NOVEMBER 10, 2014
RFI RESPONSE SUBMISSION DUE DATE	NOVEMBER 24, 2014 3:00 PM MOUNTAIN TIME

SECTION 3.0 RESPONSES

3.1. INQUIRIES

3.1.1. For inquiries about this RFI, you may send an email to: RCCORFP@state.co.us. If preferred, you may also contact the ACC RFP team by phone at: 303-866-5351. Include the RFI number and title listed in the e-mail subject line.

3.1.1.1. The Department will track the questions that it receives and aggregate the questions into an "Inquiries and Answers" document.

3.1.2. Inquiries received by the Department by the Inquiry Deadline will be responded to by the Department via a posting of the "Inquiries and Answers" document on the CORE Web site and the ACC RFP Web site. Inquiries received after the Inquiry Deadline may not be included in the Department's response.

3.2. PROTECTED HEALTH INFORMATION

3.2.1. Do not include Protected Health Information (PHI) in your response.

3.2.2. If the Department discloses the responses online or via a CORA request, unless the responder explicitly requested otherwise, responses by all Medicaid clients will be identified only by first initial and county of residence. Example: John Doe would be listed as: "'J.' Weld County." Requests for pseudonyms will generally be granted if requested.

3.3. RESPONSE FORMAT

3.3.1. The RFI is broken into the following sections:

3.3.1.1. Basic information about you, the respondent.

3.3.1.2. General Questions

3.3.1.3. Behavioral Health Integration

3.3.1.4. Care Coordination

3.3.1.5. Program Structure

3.3.1.6. Stakeholder Engagement

3.3.1.7. Network Adequacy and Creating a Comprehensive System of Care

3.3.1.8. Practice Support

3.3.1.9. Payment Structure and Quality Monitoring

3.3.1.10. Health Information Technology

3.3.2. The Department is requesting respondents to send any comments or answers, no matter how minor, to the Department. Respondents are encouraged to address the questions listed in the Response Worksheet, but you do not have to reply to all of the questions in a section.

3.3.3. Please note that early responses are appreciated. Respondents do not need to wait until SUBMISSION DATE (see Section 2.4) to submit comments. The Department appreciates receiving any and all comments from respondents.

3.3.4. Reponses should be emailed to RCCORFP@state.co.us. Your answers may be submitted as an attachment or an email. If they cannot be emailed, they may also be sent, in hard copy, to: Colorado Department of Health Care Policy and Financing, Attention: ACC Team, 1570 Grant St., Denver, CO 80203. Following receipt of your response, you should receive a confirmation email within three (3) business days.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Donna Mills
Location: Pueblo, Pueblo, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Integrated Community Health Partners, ICHP
Location: Pueblo, Pueblo, Colorado
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
- **Type or specialty:** Click here to enter text.
- **Area of practice:** Click here to enter text.

☐ Provider advocate (e.g. medical society)
☒ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☒ 3-4 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
We are RCCO 4

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
We are RCCO 4

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Community Driven
- Healthcare is Local
- Care Coordination Model
- KPI focus
- Member access

2) What is not working well in the ACC Program?

- Attribution
- Too many reporting requirements
- Too many initiatives
- Not enough time to fulfill initiatives
- KPI changes frequently
- No flexibility to be innovative with providers
- Key players not involved or incented to be involved, i.e. Hospitals, Specialists, etc.
- Payment system too fragmented

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

5) What is working well with RCCO and BHO collaboration right now?

Region 4 has implemented some processes that are very innovative, but this may not be common among all RCCO's. For example, FQHCs and mental health centers have allocated the RCCO's resources so that each patient is assigned a care coordinator. The MHCs provide care coordination for practices that are too small to be able to offer their own care coordinators; "cross pollination" where behavioral health staff spend time in medical offices and medical staff spend time in behavioral health offices; natural environment for cross-training. This "cross pollination" has led to breaking down some of the cultural challenges. Innovation has also lead to shared projects which will improve outcomes on both the physical and behavioral health side. For example, RCCO 4's diabetes outreach and education project is being done collaboratively with CHP. The BHO has representation on each of the local, care coordination teams, i.e., SLV, Upper Ark Valley, Lower Ark Valley, Pueblo.

6) What is not working well with RCCO and BHO collaboration right now?

1) Different data systems; BHO's or mental health centers do not have direct access to the SDAC; they are dependent on the RCCO to obtain the data 2) Different payment structures and owner incentives; different provider incentives; 3) RCCO has responsibility (financial) for things they have no control over, such as attribution. The BHO's may have data or resources that can help the RCCO solve this problem, but there is no incentive for the BHO to do so; 4) different member fee structures – BHO's do not charge anything for services, but there is a co-pay structure for PCMP's, and other medical providers; 5) HIPAA has been cited as a barrier by some. For example, behavioral health HIPAA rules are more restrictive than medical, and sometimes it has been difficult to share patient information.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Integrating the funding streams and aligning the financing structure between primary care and behavioral health care should be the priority. Integrated funding would require creating appropriate integrated codes and integrating data and data repositories. In addition, parity for behavioral health should be included on the SDAC – meaning 1) CMHCs who have patients in common with PCMPs should be able to access the SDAC, and 2) behavioral health claims data should be included on the SDAC. Finally, there should be some kind of alignment between the RCCO boundaries and the BHO boundaries for better efficiency and coordination. At the same time, the current BHO boundaries shouldn't be a prerequisite for determining the most appropriate RCCO region boundaries.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	Integrating the funding streams and aligning the financing structure between primary care and behavioral health care should be the priority.
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☒	☐	RCCO should have similar payment system.
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☒	☐	Integrating the funding streams and aligning the financing structure between primary care and behavioral health care should be the priority.
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☒	☐	Should have similar outcomes and have report templates and deliverables align.
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☒	☐	Organizations that serve the same members should have shared data.
Training	☐	☐	

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Others	Please type your response here.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

- Behavioral and physical health clinicians work together to design and implement a patient care plan.
- Tightly integrated, on-site team-work with a unified care plan often connotes close organizational integration as well, perhaps involving social and other services.
- The clinic provides physical and behavioral health accessible in a common setting (one stop shop).
- Clinic clinicians use a common patient health record/HIE.
- The clinic is accountable for population health and cost management measures reflective of integrated care.
- The clinic should have the capacity to deliver, arrange, coordinate and be accountable for the majority of a person's/family's care.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

It's important for integration to occur within the Department as well. The BHO and RCCO contract managers do not spend enough time with each other to fully understand their programs. If there is more integration within the Department at the operational level, some new strategies will naturally arise from these relationships.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

- Recognition that health care is local
- Collaborative, partnership approach
- Driven by patient and family in collaboration with the entire health care Team
- Meets the Triple Aim
- Assessing the needs and available resources of the Member
- Identification of gaps in care
- Linking Members to necessary resources
- Facilitation of communication among multiple agencies
- Meets State and Organizational requirements

b. How should RCCOs prioritize who receives care coordination first?

- Based on pre-defined risk stratification
- As identified by immediacy of situation of individual Member
- As identified by referral from Primary Care Provider, Community Mental Health Center and/or the Healthcare team

c. How should RCCOs identify clients and families who need care coordination?

- Via data from HCPF
- Specific population health criteria (children and MMP Members)
- Identified case needs on individual basis, by the Primary Care Provider, Health Care Team, Community Mental Health Center and/or community partners engaged with the Member

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

- Health care is local
- Each medical provider uses internally-developed systems
- Reporting to Performance Improvement, Quality and RCCO database to meet HCPF reporting requirements.

12) What services should be coordinated and are there services that should not be a part of care coordination?

- Housing, food, physical and behavioral health needs, prescriptions, health and lifestyle education should be part of care coordination.
- Transportation, financial resources and non-health education (literacy levels) should not fall to care coordination. Care coordination is only able to connect the Member with available resources.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

- Accurate contact information
- A personal interview with Member to conduct comprehensive needs assessment to identify gaps in care.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

- Medical and psychosocial
- Gaps in care analysis
- Referrals and linking to available resources

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

- Department of Social Services (Adult Protective Services and Child Protective Services)
- Long-term Support Services
- EPSDT screenings
- Healthy Communities
- Handicapped Children's Program
- All areas are different for special populations. RCCOs role is to facilitate necessary care coordination.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

- Recognition that health care is local and care coordination is accomplished at the level closest to the Member.
- Communication is key
- Work collaboratively with involved agencies to determine who takes the care coordination lead.

d. What are the gaps in care coordination across the continuum of care?

- Hospital admissions and discharges
- SNF/LTC admissions and discharges
- ER visits
- EHR differences
- Data collection and reporting

- **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	Should the RCCO have a role? No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☒	
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	
Daycare / childcare	☐	☒	☐	
Economic stability & employment	☐	☒	☐	
Education	☐	☒	☐	
Environment	☒	☐	☒	
Food access / nutrition	☒	☐	☒	
Health literacy	☒	☐	☒	

Housing	☒	☐	☒	
Language or translation services	☒	☐	☒	
Literacy	☐	☒	☐	
Transportation	☐	☒	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

- **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	Coordinate care? No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☒	Team member
Certified Addiction Councilors	☒	☐	
Certified Nurse Midwives	☐	☒	Team member
Community Health Workers	☒	☐	
Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☐	☒	Team member
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☒	☐	
Licensed Mental Health Counselors	☒	☐	
Licensed Professional Counselor	☒	☐	
Masters of Public Health	☒	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☒	Team member
Nurse Practitioners	☐	☒	Team member
Patient Navigators	☒	☐	
Peer Advocates	☐	☒	Team member
Promotoras	☒	☐	
Psychiatrists	☐	☒	Team member
Psychologists	☐	☒	Team member
Registered Nurses	☒	☐	
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	

Other	Please type your response here.

- **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☐	Refer to specialty care
Children	☒	☐	Refer to specialty care
Children who are healthy, but in socially-complex environments	☐	☒	
Children involved in the foster care system	☒	☐	Refer to specialty care
Children with a chronic illness	☒	☐	Refer to specialty care
Children with a serious emotional disturbance	☒	☐	Refer to specialty care
Children with medical complexity	☒	☐	Refer to specialty care
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	Refer to specialty care
Transition-age adolescents	☐	☒	
Parents and families	☐	☒	
Pregnant women	☐	☒	
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☐	☒	
Adults with a chronic illness	☒	☐	Refer to specialty care
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	Refer to specialty care
Clients involved in the criminal justice system	☒	☐	Refer to specialty care
Clients with a disability	☒	☐	Refer to specialty care
Clients in a nursing facility	☒	☐	Refer to specialty care
Elderly clients	☒	☐	Refer to specialty care
Frail elderly clients	☒	☐	Refer to specialty care
Clients in palliative care	☒	☐	Refer to specialty care
Other populations, please comment:			

18. How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

- Collaborative coordination and communication with Child Protective Services
- Direct work with foster care families as necessary for housing and transportation
- Identification of lead care coordinator and internal available resources for assistance as needed

19. How should care coordination be evaluated? How should its outcomes be measured?

- Identification of positive impact on individual basis
- Key Performance Indicators identified by HCPF
- Quality measures identified by HCPF and Performance Advisory Committee

20. Today RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21. Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐

4,001-5,000	☐
More than 5,000	☐

22. How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23. Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24. If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Although some standardization is important, too much stifles innovation. Data set reporting to and from RCCOs is probably appropriate, however, provider contracting, payment methodologies and the like need to be nimble to accommodate community needs and nuances.

25. What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Health and healthcare is local. In order for a bidder to understand community strengths and needs, as well as form or maintain community relationships they have to be part of the community. Although ICHP's office is located in Pueblo – we have developed strong relationships with the communities throughout our region. Having doors opened throughout the RCCO has taken time and real relationship building. We have leveraged the strengths and relationships currently held by our safety net providers region wide who are also owners of ICHP.

26. The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27. Should the RCCO region maps change? Why or why not? If so, how?

There may be value in the RCCO region maps changing if they align with patient access, utilization patterns.

28. Should the BHO region maps change? Why or why not? If so, how?

29. Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30. What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

    - Lock-in auto assign
    - Manage population and attribution

31. What are the limitations of the current benefit structure and what – if any – changes are needed?

    No client incentive to use proper point of care.

32. Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

    - Absolutely not.

33. If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34. What role should RCCOs play in attributing clients to their respective PCMPs? If a PCMP can provide evidence of a patient relationship, the RCCO should be allowed to attribute that member to the PCMP.

35. What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

Contract requirements, outcomes, and deliverables should align across agencies. To have the ACC required to impact outcomes that are primarily governed by other agencies or organizations sets the RCCOs up for failure. We should also be able to share data.

36. What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

Contract requirements, outcomes, and deliverables should align across agencies. To have the ACC required to impact outcomes that are primarily governed by other agencies or organizations sets the RCCOs up for failure. We should also be able to share data.

37. What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

Connect for Colorado and the ACC program should have the same policy for income eligibility. Also both programs should have continued Adult eligibility for 12 months.

38. What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

The Department needs to have more interaction with the Division of Insurance to determine ACC Program goals.

Stakeholder Engagement

39. What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

The RCCO should have a meaningful feedback loop between client/family/advocate stakeholders and decision-makers. 1) The RCCO should be allowed to do appropriate screening and training of client/family/advocate stakeholders to ensure their feedback and participation can have a meaningful impact on RCCO operations or goals, and not just be a committee that airs individual grievances or gives recommendations that are impossible to implement. 2) There should be a formal mechanism to communicate stakeholder recommendations to executive decision-makers. 3) Depending on the participants that are identified, the RCCOs can create a stakeholder committee, workgroup, or subcommittee that feeds back to a larger committee. 4) If the department sets requirements for membership (i.e. 50% clients with diabetes, 20% clients with behavioral health, etc.), this can lead to a committee that is not able to give meaningful direction, because it is not always possible to find stakeholders from specific target groups that are willing or able to participate meaningfully. There should not be prescriptive requirements about membership; 5) there should be a formal way for the leadership to respond to recommendations from this committee or workgroup.

40. What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

Broad stakeholder participation builds support for the program. Partnerships with providers, community organizations and provider associations are necessary to getting provider acceptance and support. These stakeholders can be engaged in multiple ways, including holding forums to resolve common problems; structured interview templates asking provider questions about service delivery problems and solutions; holding educational summits; establishing a larger committee with workgroups specific to addressing local problems. Because each community is unique, the requirement should allow for flexibility in how the provider stakeholder feedback is received (face to face meetings, survey templates, web meetings, etc.), and should describe how the feedback is communicated to leadership in operational and executive roles.

41. Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

Systems integration or outreach activities that occur on a local level can lead to increased communication, shared decision-making and collaboration among community agencies. This has to occur on a local level because understanding the culture and politics of a community are necessary. The Department should be willing to participate in some of these outreach activities, because the Department's presence can add credibility to the RCCO's goals and strategies.

42. How should the Department structure stakeholder engagement for the ACC as a whole?

The Department should also be willing to establish and host a state-wide stakeholder committee, where RCCO representatives and representatives from major stakeholder groups throughout the state meet on a regular (bi-monthly?) basis. This will give the Department the opportunity to hear from all regions how they are addressing specific issues, and how or whether or not they are affecting individual RCCO's. Any requirement to RCCO's for stakeholder feedback mechanisms should be flexible enough to allow the RCCO's a way to build a format that meets their local, geographic and cultural needs.

Network Adequacy and Creating a Comprehensive System of Care

43. Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

No

a. If no, what are the gaps?

Access to specialists and dentists outside of populous areas of the region are concerns. There are issues around accessible transportation for Medicaid individuals to specialists and other health care related appointments.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

Access to specialists for the population as a whole is a concern which include children/families and individuals with disabilities. County agencies arranging transportation services should be required to maintain a schedule and have appropriate turn-around-times to ensure availability of transportation services.

44. ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

Hospitals need to become more engaged in the ACC program.

b. What role should pharmacies play in the next iteration of the ACC Program?

The pharmacies have a role, however; rules and function need to become integrated at a State level. Agencies all need to be measured on same performance level.

c. What role should specialists play in the next iteration of the ACC Program?

The specialists have a role, however; rules and function need to become integrated at a State level. Agencies all need to be measured on same performance level.

d. What role should home health play in the next iteration of the ACC Program?

The home health agencies have a role, however; rules and function need to become integrated at a State level. Agencies all need to be measured on same performance level.

e. What role should hospice care play in the next iteration of the ACC Program?

The hospice care agencies have a role, however; rules and function need to become integrated at a State level. Agencies all need to be measured on same performance level.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

The SEPs and CCBs have a role, however; rules and function need to become integrated at a State level. Agencies all need to be measured on same performance level.

g. What role should counties play in the next iteration of the ACC Program?

The counties have a role, however; rules and function need to become integrated at a State level. Agencies all need to be measured on same performance level.

h. What role should local public health agencies play in the next iteration of the ACC Program?

The local public health agencies have a role, however; rules and function need to become integrated at a State level. Agencies all need to be measured on same performance level.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

The community organizations and non-profits have a role, however; rules and function need to become integrated at a State level. Agencies all need to be measured on same performance level. Yes, these populations have been overlooked in the past.

45. How can RCCOs help to support clients and families in making and keeping appointments?

The PCMP should be able to manage the clients appointments and the RCCO should provide support if needed.

The disenrollment guidelines should be relaxed. RCCO's should be able to set clear expectations about missed appointments with a provider, for example, in the Member Rights and Responsibilities Statement. Other large public systems such as the VA set clear guidelines when someone becomes enrolled, reminding patients that missed appointments waste resources that another patient could have used. 3 or 4 missed appointments should be grounds for a provider being able to discharge a member. Once we are allowed to set clear expectations, we can work to help members overcome real barriers they experience. Suggestions include: 1) appointment reminders using text, e-mail or telephone 2) doing follow-up with members who have missed two appointments 3) offering appointments outside regular business hours 4) assigning chronic no-shows to care coordinators who can help them identify and solve other barriers.

46. Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47. **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48. Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

In order for the RCCO's to do a thorough and effective job in coordinating dental care, it makes more sense for dental benefits to be structured through the RCCO. This would allow the RCCO to conduct the same activities they do with medical services – recruit providers, offer provider support and practice transformation services, integrate dental services with other services in care coordination activities, provide the full array of customer service activities. In the current structure, there are operational boundaries, in that the RCCO's can't recruit providers and offer them the same level of support they do for PCMP's. If there are issues with providers, the

RCCO's don't have the same level of authority to resolve problems. While the RCCO's can still provide care coordination and customer service to members seeking dental services, they don't have the means to recruit providers or resolve provider issues in the current administrative structure.

49. Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

Cultural Competence in healthcare is the ability to understand and accept the impact that culture has on the health care encounter, the way patients view health, illness and healing, the way patients communicate in a health care setting, and the ability of the health care provider (including staff) to acknowledge these factors and modify their own communication style in order to communicate effectively with patients and their families.

b. What RCCO requirements would ensure cultural competency?

Putting together a cultural competency plan would ensure that the RCCO's recognize the importance of culture in the healthcare experience, and are willing to set goals to help them improve their own and their staff's cultural competency.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

First, cultural competency is a process, not an event, so it is difficult to articulate specific skills that make people culturally competent. Also, because someone has a skill does not mean they are culturally competent. There are several things that need to occur, however - 1) need to have a basic understanding of their patient's cultural backgrounds; 2) need to have a basic understanding of patient attitudes and behaviors that might impact the health care encounter; 3) have an understanding of their own cultural values and whether the values translate to behavior that has an impact on their patient's health care experience. These can all be addressed through training.

d. Low health literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Some of this was addressed in "c" above. Other things will address this problem 1) training staff about low health literacy and the impact it has on patient outcomes; 2) RCCO's have a policy for securing interpreters and assisting patients with low English proficiency.

50. Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51. Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

It is important to acknowledge that higher ER use has not been associated with higher total costs of care in Region 4. However, increasing primary care access by reducing ER use is desirable to increase access to preventative services and treatment adherence to all the care issues a patient is experiencing (not just the chief complaint that presents to the ER). The RCCO should be empowered to create incentives for patients and hospitals to reduce unnecessary ER use understanding that hospitals have to abide by EMTALA. The ACC should also explore what disincentives could be implemented that deter ER use but do not negatively impact patient safety or arbitrarily penalize hospitals for following EMTALA.

52. Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53. **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☒	☐	☐	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☒	☐	☐	☐
Provide registries	☒	☐	☐	☐
Offer client reminders	☐	☒	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☒	☐	☐	☐
Supply behavioral health surveys	☒	☐	☐	☐
Supply other self-screening tools	☒	☐	☐	☐
Administer behavioral health surveys	☐	☒	☐	☐
Administer other self-screening tools	☐	☒	☐	☐
Prepare client action plans	☐	☒	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☒	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☒	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☒	☐	☐	☐
Provide standing pharmacy order templates	☒	☐	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☐
Provide directory of other resources	☒	☐	☐	☐
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others				

54. If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55. What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56. What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

Incentive payments through PMPM system for nationally recognized practices that are certified medical homes.

57. Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58. Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59. Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

    Giving the RCCOs more control over how to distribute the financial incentives and the provider funding would be helpful. Currently, the payment structure is such that any PMPM or incentive payments come directly from the State, which does not incentivize PCMP organizations to collaborate with the RCCO. In addition, high performing PCMPs should be rewarded for their performance and not make it contingent upon the entire region meeting a specific threshold. The current payment structure still pays for volume, not quality – but until the attribution issue is resolved, payment reform will be difficult.

60. If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

    It should also be a goal of the ACC to make risk adjustments that deals with the social determinants of health.

61. Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

    Some providers (primarily the FQHCs and large PCMPs) have the infrastructure to be successful in a pay for performance environment. However barriers, such as funding for facility improvements and EHRs, are significant at smaller provider practices in more rural and frontier areas. Therefore, they are not currently affordable. Without the appropriate facilities and EHRs that can extract and exchange data with an HIT, payment for value is difficult to determine and/or manage.

62. The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

We are not currently licensed, but the requirement would not preclude us from bidding, although it would be considered a costly barrier. There is significant uncertainty, also, with respect to the State's policy decision about DOI requirements. The acquisition of a license is a significant investment of time and money. With time running out before the RFP rebid, it becomes less and less feasible for our RCCO to acquire a license as long as there is not clarity on this element of program design.

63. What role – if any – should the RCCOs play in the distribution of payments to providers?

RCCOs should play a more significant role in the distribution of payments to providers in order to maximize the RCCO's potential. Meaning, this will allow RCCOs more flexibility to reward and incentivize good behavior/outcomes and hold providers accountable for unwanted behavior/outcomes.

64. Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

Due to the history of Managed Care in Colorado, consider phasing in various components of care into a managed care/capitated payment system. For example, start with the most common primary care outpatient visits and over time, increase the number of services covered. This would allow practices to become more familiar and comfortable with the new payment structure, give them sufficient PMPM to enhance services and invest profits back into their practices, and ease patient's concerns that managed care equals no care.

65. What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

HEDIS Measures, Meaningful Use, NCQA and UDS (FQHC) data and other current measures could be incorporated into the payment incentive structure initially. An important consideration to remember is that whatever measures we choose, we must modify the current RCCO structure to give us more jurisdiction over the measures. (For example, ER visits have a lot to do with how hospitals are organized, where they are geographically located, and how they use that department as a significant funding stream. However, hospitals are not part of the RCCOs.)

Measures that focus more on preventative care and/or routine check-ups can also be incentivized more heavily. This, albeit slowly, will help change the overall culture of the American population from "Doctors are who I see when I am sick" to "Doctors are who I see to keep me well." We'll never bend the cost curve focusing on sickness and illness burden only.

66. **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	Because CAHPS is really one of the few tools available to multiple States, being able to compare data is helpful. However, CAHPS has not come up with a truly integrated assessment yet, which is really what Colorado needs.
SF-12 Health Survey	☐	☒	The SF-12 seems less helpful and appears it may be phased out.
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☒	☐	LOVE the PAMS – can we get this implemented statewide???
Focus groups	☒	☐	Focus groups can be helpful for very targeted questions. However, it is difficult to get a diverse, cross-section of participants and turn-out is typically minimal.
Other	Please type your response here.		

67. Knowing that, at this time, the Department only has claims data, how should population health be measured?

Population health could be measured based on diagnosis, age range, geographical proximity or other pertinent demographics. Decide on a particular cohort and then determine the best methodology for assessing wellness level (or conversely illness burden) within that cohort.

68. How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

It should be open and transparent, but given the enormity of this endeavor, a vetting process with the RCCOs and PCMPs should be completed prior to placing anything out in the public domain on a "report card" type website.

69. **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but

they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70. What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☒
21-30%	☒
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

If the focus becomes too diversified, the practices will quickly become overwhelmed and no measures will show considerable improvement. **If everything is important, then nothing is important.**

Practices need to have a base funding stream that is guaranteed in order to implement necessary changes to become enhanced primary care practices. If more than 20-25% of the funding is predicated to measures or performance, this may discourage participation. (20% to no more that 25% of RCCO payments should be tied to measures or performance, initially allowing time to take a baseline and get programs up and running.) However, over time, performance can and should ultimately become the dominant determinant for payment.

71. Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

RCCOS across the State should be paid on a core set of KPIs with additional elective KPIS being offered and available. Some RCCOs have concentrated populations that grapple with a particular issue (like diabetes in Alamosa or teen pregnancy in Pueblo) that may be different in other RCCOs. Having a core set plus an elective set allows the state to compare core elements across Colorado while also giving RCCOs some more flexibility within their regions.

Once the SDAC is able to 1) show practice KPI trending and 2) show this trending at a more granular level, practices should receive KPI incentives If they meet the criteria. Having all practices within a RCCO either receive or not receive an incentive payment based on an aggregate allocation does not incentivize sufficiently and can actually demotivate provider practices.

72. Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

    Based on improvement. The one KPI (Well child checks) predicated on achieving national standards has yet to pay out any incentive payments to any RCCO in any part of Colorado. In fact, it has now become a dis-incentive, as practices work hard to achieve this goal and even if they are at 100% compliance, because their entire Region is not hitting the national benchmarks, they are not getting any incentive payments.

73. Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

    Yes, payment should be tied to measures where data can be provided on a monthly or regular basis. Ideally, payments would be done quarterly. Monthly can become too cumbersome and annually does not provide the 1) positive reinforcement, and 2) the motivational incentive to modify a practice workflow or provider behavior in a timely enough manner. Annually, the interval between cause and effect is too great.

74. **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75. For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

    The administrative costs of operating a RCCO are fixed costs.

76. For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

    The RCCO has developed an audit tool for clinical and technical chart reviews to measure/assess the quality of care delivery at the practice level. However, it is not reimbursed at this time.

Health Information Technology (HIT)

77. **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☒
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☐	☒
Smartphone app	☐	☒
Other: The key here is that we must be flexible to whatever mechanism the client has access to and is comfortable with using. We must meet the client how and where they want to be met.		

78. **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☒	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☒	☐
Practice assessment tools	☒	☐
Practice management tools (scheduling, billing)	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☒
Patient education/wellness tools	☒	☐
Provider/case manager directory	☒	☐
Shared decision-making tools	☐	☒
Telemedicine software	☐	☒
Other:	☐	☐

Other:	☐	☐

79. **Importance of technology by type**. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☒	☐
Electronic Health Records (EHRs)	☐	☐	☐	☒	☐
Practice assessment tools	☐	☐	☒	☐	☐
Health risk assessment software	☐	☐	☐	☒	☐
Practice management tools (scheduling, billing)	☐	☐	☒	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☒	☐
Patient education wellness tools	☐	☐	☐	☒	☐
Provider/case manager directory	☐	☐	☐	☒	☐
Shared decision-making tools	☐	☐	☐	☒	☐
Telemedicine	☐	☐	☐	☒	☐
Other:	☐	☐	☐	☐	☐

80. What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

The cost of implementing these tools, as well as maintaining or modifying them is a major barrier. The second barrier is that there are so many vendor tools to choose from, and they do not share a common structure for communicating between them (the data exchange standards either do not exist for all type of data to be communicated, or they are not robust enough to do so at this time).

81. How can Health Information Technology support Behavioral Health Integration?

    It is a common misconception that Behavioral Health data is significantly different from Primary Care data – it is not. The structures that hold both sets of data are virtually identical. The more exercises Information Technology systems can perform with Primary and Behavioral data integrated into the same structures, the faster the clinical paradigms about the need to separate these two sets of data will disappear.

82. In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

    A shared resource for data and analytics makes sense when trying to compare and contrast different populations and different regions. However, shared resources can also be restrictive and misleading, if they are not implemented correctly. The raw detail data beneath any analytics should be widely available to the RCCOs, so that they may learn, validate and correct issues that they find within. Additionally, this allows RCCOs to create new and region or population-specific measure that may be of benefit to the client.

83. Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

    A shared care management tool would create a significant amount of efficiency for a RCCO. The larger the user base for sharing the better. A care management tool shouldn't be limited to only a single payer because that creates barriers to adoption of the tool for the PCMP. The tool will need to include the universe of lives managed by each PCMP for it to be effective. The basic elements of a shared care management tool is that it needs to be data driven from claims, practice EHRs and the HIE.

84. Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

    It doesn't matter if the population health management tool is widely shared or used just within a single RCCO. The users of the tool would be the RCCO leadership so the only benefit to using a shared tool could be economies of scale and apples to apples comparisons between RCCOs.

85. Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

A provider directory would be most useful as a shared platform to direct and exchange messages with providers and coordinate care in an effort to leverage all participants involved in the patient's care and resources available as well as maximize all opportunities for support and intervention.

86. How can the RCCOs support providers' access to actionable and timely clinical data?

RCCOs should be working with providers, including PCMPs, hospitals and specialists, across their region regarding how data will be shared. These conversations should happen within a state wide context as often patients and providers cross RCCO region lines. RCCOs could both be supportive of efforts to join CORHIO to achieve the outcome of sharing actionable and timely clinical data, and they could also be implementing requirements that providers engage in these efforts.

87. What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

There are many HIT solutions which would provide benefits to clients, providers and RCCOs. Patient access to web portals to track their health information and direct messaging with providers would be useful in engaging patient in their health. Telemedicine, especially in relation to accessing specialists, would beneficial in expanding access to care. Instant communication in the form of email or text when a patient presents in the ER would be beneficial to case managers.

88. What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

RCCOs should be encouraging participation in CORHIO and including technical assistance with that process, which would address a requirement that they should have to ensure the flow of information across systems. Additionally, RCCOs should be providing support to Meaningful Use and PCMH, which could be simply coordinating with organizations that provide support in this area. RCCOs will need to be compensated for these services.

89. What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

CORHIO has a large role to play in successfully developing the data systems which will allow real-time, clinical data to be shared, which is required to fully realize the benefits of care coordination. Many of the barriers that were alluded to in the questions of this RFI, such as is a single system needed for a particular purpose across a region, are issues CORHIO has already been working on solutions to, so they should be included as a partner in these efforts from the beginning.

90. Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Implementing new and innovative technologies, no matter how practical or cost-effective (even free), will always face resistance from providers who need to focus on getting paid first. For example, a free tool that offers everything that a provider would want to know on the status of their patient, risk stratifications, and health conditions, in real time, will always take second seat to the system that results in the provider getting paid for their services (such as an EHR with utilization management and billing modules). Asking the provider to perform duplicative data entry into both systems is not a palatable solution to them, but if a system were to be released that encompasses all of the features and functionality, above, it would most likely be very well received and widely adopted.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 043

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Deborah Foote
Location: Nederland, Boulder County, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Oral Health Colorado
Location: Nederland, Boulder County, CO
x Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
x Other (please describe): Comprehensive oral health advocacy

Are you currently involved in the ACC program?

☐ Yes
x No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Provide input at PIAC

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Oral health network of organizations dedicated to insuring Medicaid dental benefits are available, accessible, and utilized.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

2) What is not working well in the ACC Program?

✓ There is a lack of recognition that oral health is an important component of a person's total well-being and a component of integrated care. This is despite the fact that oral health is connected to three of the four KPIs for FY 13-14. Specifically ACC should recognize:

- there is increasing evidence that a number of hospital readmissions are due to untreated dental disease
- some patients are using the ER for oral health needs in areas that lack access or because referrals are not made- thus a patient is only receiving care to treat symptoms and not the dental disease itself
- well- child visits are an ideal opportunity for oral health education/interventions. Colorado Medicaid pays medical providers who meet certain training criteria (Caving Free at Three, Smiles for Life) for oral screenings and application of fluoride varnish.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to ad
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	✓	☐	Dental does not currently use diagnosis codes

[1] Many terms and definitions can be found in the Appendix at the end of this document.

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

			making outcome measures challenging
Different behavioral / physical health reimbursement	✓	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	✓	☐	
Training	✓	☐	Training on intersection of oral health with physical health and behavioral health
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

✓ As a minimum standard, referral to a dental home.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

✓ Care coordination includes all aspects of total health- including oral health

b. How should RCCOs prioritize who receives care coordination first?

c. How should RCCOs identify clients and families who need care coordination?

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

- ✓ For adults with a concurrent medical condition/diagnosis-particularly diabetes and heart disease, care should be taken to coordinate services between the medical specialist and dental provider.
- ✓ Preventive oral health services between medical and dental providers.
- ✓ RCCOs include Cavity Free at Three messaging in provider communications. RCCOs encourage primary care providers, including family practice physicians, pediatricians, ob/gyns, physician assistances and nurse practitioners, to contact CDPHE for Cavity Free at Three training. (Medicaid and CHP+ requires certification to bill for Cavity Free at Three medical services)
- ✓ Add Medicaid dental providers to RCCO communications. Encourage dental providers to receive Cavity Free at Three training.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

- ✓ In respect to adult health, A1C, cardiac diagnoses, untreated dental needs, access to preventive care.
- ✓ In respect to children's health, untreated dental needs, access to preventive care.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma		☐	☐	

Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	x	☐	☐	Educate patients about proper oral health behaviors, benefits and access to oral health preventive and restorative services- and address cultural barriers to care. Educate providers about importance of the access to oral health care.
Environment		☐	☐	
Food access / nutrition	x	☐	☐	Advocate to fill food deserts with low-cost grocery stores, food pantries with healthful meals that promote good oral health.
Health literacy	x	☐	☐	Ensure patient education materials are available at points of service in culturally appropriate language.
Housing	☐	☐	☐	
Language or translation services	x	☐	☐	Ensure services as part of care coordination.
Literacy	☐	☐	☐	
Transportation	x	☐	☐	In coordination with HCPF. Ensure transportation vendor is timely and convenient for patients and available for all health services
Other	Educate on the importance of fluoride in oral health and routes of access (tap water, supplements) and how certain water filtration systems remove fluoride, bottled water does not have fluoride, etc.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	**Coordinate care?**	**In what capacity should these individuals coordinate care in the ACC Program?**

	Yes	No	
Advanced Practice (Registered) Nurses		☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers		☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches		☐	
Licensed Clinical Social Workers		☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators		☐	
Peer Advocates	☐	☐	
Promotoras		☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Dentists, dental hygienists		

17) **Care coordination requirements for specific populations**. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	x	☐	Oral health assessment should occur before age 1
Children	x	☐	Unique oral health assessment, assure fluoride varnish, sealants
Children who are healthy, but in socially-complex environments	x	☐	Same as "children"
Children involved in the foster care system	x	☐	Same as "children"
Children with a chronic illness	x	☐	Same as "children" plus medication impact on dental status (dry mouth)
Children with a serious emotional disturbance	x	☐	Same as "children" plus medication impact on dental status
Children with medical complexity	x	☐	Same as "children" plus medication impact on dental status
Children or youth with a behavioral health diagnosis or substance use disorder	x	☐	Same as "children" plus medication impact on dental status and intersection of certain substances (ex. Crystal meth) and its impact on oral health
Transition-age adolescents	X		Same as "children" with recognition that this age group has significant decrease in dental visits compared to early ages
Parents and families	☐	x	Oral health education to encourage best practices for children
Pregnant women	x	☐	Oral health assessment due to intersection of dental disease and pregnancy outcomes, oral health education on transmission of caries from mother to child
Adults	☐		
Adults who are healthy, but in socially-complex situations	x		
Adults with a chronic illness		x	Assess medication impact on dental status and illness with dental influences/impacts
Adults with a behavioral health diagnosis or substance use disorder		x	Assess medication impact on dental status
Clients involved in the criminal justice system	x	☐	
Clients with a disability		x	Assessment of disability on impact to engage in optimal oral health practices and access to oral health provider
Clients in a nursing facility		x	Assess oral health status impact on physical health, impact of medication on oral health status, and limits on accessing care outside facility

Elderly clients	☐	x	Assess oral health status impact on physical health, impact of medications on oral health status
Frail elderly clients		x	Assess oral health status impact on physical health, medication impact on oral health and ability to access to care in community
Clients in palliative care	x	☐	
Other populations, please comment: Families of clients who are high utilizers, including families of children requiring operating room dentistry to manage dental disease.			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

   a. What is the PMPM cost for providing care coordination services?

   b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

   a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

- ✓ Needs to include coordination with a dental home in order to ensure overall health of the client.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

- ✓ Inclusion of oral health professionals- safety net providers and private practitioners

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

- ✓ Assure inclusion of oral health subject matter experts/advocates to help facilitate integration of oral health

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

- ✓ No.

a. If no, what are the gaps?

- ✓ Inadequate number of dental specialties for both adults and children, especially oral maxillofacial surgeons, periodontists, endodontists and pediatric dentists.
- ✓ Certain areas of the state have no access to dental providers.
- ✓ With Medicaid expansion and the addition of the Medicaid adult dental benefit, the majority of current dental providers are overwhelmed with pent up demand for care and the current average reimbursement rate for non-FQHC providers is only at 45% of usual and customary- which may continue to be a factor in dental providers not enrolling in Medicaid or only accepting a few patients.
- ✓ Rural communities may be unable to attract dental providers due to high cost to provider in establishing dental suite. Communities may need to look to community sponsorship of dental suite.

✓ No current opportunity to full utilize tele-dentistry. Hopefully can be option in 2016 due to upcoming legislative efforts.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

✓ Educate dental providers, specialists included, about Medicaid program. Focus on provider concerns about patient panel, reimbursement rates, speed of reimbursement and business case for care coordination.

✓ Facilitate provider trainings to expand patient panel to include people with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

✓ Looking at solutions for moving clients from receiving ED care for oral health conditions to receiving necessary dental care to address the condition.

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

✓ Requirement for both CHW and PN- and include expertise in oral health.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	
On staff (salary) at RCCO	
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

✓ Coordinate with DentaQuest's outreach coordinators to evaluate priority communities lacking dental providers, including specialists. Support DentaQuest and Colorado Dental Association dental provider recruitment efforts. As virtual dental home evolves, support policies that reimburse for Teledentistry services and provide care coordination.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

✓ Cultural competency enables providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients.

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

✓ Culturally appropriate care coordination that includes oral health care, including recruitment of navigators and/or promotores from local communities

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

- ✓ ER use has been a traditional point of "service" for oral health emergencies. With addition of adult dental in Medicaid, strategies should be employed to assure access to appropriate dental care.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐

Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others	Integrate oral health into any of the above where applicable			

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

- ✓ Require oral health education, screening and referral to dental providers

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- ✓ Current Medicaid dental services reimbursement averages about 45% of U&C. In order to increase access for the ACC population, enhanced reimbursement should be explored to encourage private providers to provide services to this more complex population.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience**. Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

✓ Utilization of preventive versus emergency services. Frequency of preventive services for management of chronic disease, including dental and periodontal disease. Community and family level "hot spotting" of high utilizers.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

✓ GIS maps for KPIs and quarterly data reports on access to preventive services versus emergency services, including oral health

69) **Measures for payment**. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐

Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and S are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☐
Care management tool	☐	☐	☐	☐	☐
Care transitions alerts	☐	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☐
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

81) How can Health Information Technology support Behavioral Health Integration?

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

- ✓ Care management tool should include oral health needs/services to alert providers to potential oral health impacts on other medical conditions and vice versa

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

- ✓ Tool needs to include oral health measures

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

- ✓ Inclusion of oral health providers to facilitate referrals and integration

86) How can the RCCOs support providers' access to actionable and timely clinical data?

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of
Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 044

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Arnold Salazar
Location: Alamosa, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Health Partnerships
Location: Western/Southern CO
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted -- Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☒ Potential bidder for RCCO contract
☒ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☒ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Colorado Health Partnerships (CHP) is one of the 5 BHOs, as such we have working relationships with RCCO 1, 4,and 7.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Behavioral Health provider for the western/southern parts of the state covering 43 counties.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

   - Program is close to the community. I've observed some of the local solutions that have been addressed by the RCCOs that have been very effective. Having multiple RCCOs working on local solutions and sharing these solutions with each other will have greatest impact.
   - Focuses on local solutions – can be customized to meet local needs.

2) What is not working well in the ACC Program?

   - Payment reforms are moving too slow to have significant impact on cost and quality of care. We are still largely tied to a fee for service system that is volume driven and not focused on quality outcomes. The question of how to transition provides away from Fee for Service and on to payment for quality has eluded almost everyone. While KPIs have been tried and have had some impact, they can have only limited impact on cost. A risk model that focuses on cost as well as quality and access will prove to be a much more effective reform tool in my opinion.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

   - The BHOs have been able to control costs over a long period of time while providing access to more members. BHOs have figured out how to manage provider risk which must be a key component of any payment reform initiative.

4) What is not working well in the BHO system?

   - The payment structure over time has moved too much toward encounter reporting which has its roots in Fee for Service. HCPF has not been able to move to outcome based reimbursement which I think should be the end goal.

5) What is working well with RCCO and BHO collaboration right now?

   - The joint RCCO – BHO meetings have been very productive. At the local level we have three different relationships with the RCCOs in our region, RCCOs 1, 4 and 7. What works is the flexibility to develop local solutions. This feature must be a prominent part of the next RCCO bid.

6) What is not working well with RCCO and BHO collaboration right now?

   Progress toward payment reform is much too slow. SDAC data is still not being shared with the BHOs at a level that could help coordinate care in a much more effective manner.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The RCCO RPF should encourage integration. Bidders should be rewarded with higher scores for closer integration of programs, data and finances.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) Barriers to the integration of behavioral health and physical health services. Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☒	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☒	☐	it would be much easier to integrate if we did not have a limited diagnosis list; however I understand the cost implications of opening this up to all diagnosis and codes. A barrier isn't always a bad thing (won't put this in my response but you might give some thought.)
Different behavioral / physical health reimbursement	☐	☒	
Institutions for Mental Diseases exclusion	☒	☐	Although this is an issue, the 1915 (b)(3) waiver offers some flexibility through the Medicaid Managed Care program.
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	Better addressed by the MHCs
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☒	
Physical space constraints	☐	☒	
Privacy Laws (HIPAA, 42 CFR)	☒	☐	42 CFR is a real problem with care coordination; HIPAA however is not an issue.
Professional / cultural divisions	☒	☐	This is one of the many challenges we have found. The BHO and MHCs have some very rich experience in this area.
RCCO or BHO contracts	☐	☒	
Staff capacity	☒	☐	Staff capacity is an issue for all of health care in Colorado. BHOs and MHCs face those same challenges.

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

State/Federal rules or reporting requirements	☒	☐	The reporting requirements need to be aligned.
Technical resources / data sharing	☒	☐	SDAC data needs to be shared with the BHOs
Training	☐	☒	
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

- We think that the six levels of integration best reflect what we need in the field.

  http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

- The deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services

b. How should RCCOs prioritize who receives care coordination first?

- While prioritizing care coordination may be required due to resource concerns, we should not forget that minor problems can escalate and sometimes our most effective care coordination prevents the escalation of health problems. Having a role for providers outside the RCCO to coordinate care is still a valuable resource. Defining the role of the RCCO and the providers so that care coordination is not duplicated should be a focus of the RCCO bid.

c. How should RCCOs identify clients and families who need care coordination?

- Care coordination should occur at the primary care (bi-directional) level for anyone accessing more than one health care system.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

- I don't understand the context in which this question is asked.

12) What services should be coordinated and are there services that should not be a part of care coordination?

- All services should be coordinated including services outside the medical visit that impact the health care of the Medicaid member; including Social Services and Public Health .

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

- Care coordinators need to know how patients access primary care inciuding bi-directional service locations,(locations where behavioral health clients receive their primary care.) All care for specialty should be accessed through the primary care provider and should be coordinated by the RCCO.

14) Many clients and their famiiies have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

- Care coordination is happening at aii ievels which is part of the problem. The RCCO bid should seek to consolidate this process and reward bidders for identifying and then developing systems that address the issue of multiple care coordination systems.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

- BHOs are required to coordinate care for Behavioral Health patients. This sometimes can be in conflict the care coordination required by the RCCOs. Colorado Heaith Partnerships through its Mental Health Center providers has worked to make this an effective process. I beiieve this could be used as a modei for how other system of care coordination is brought under the RCCO process.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

- By centralizing care coordination with the RCCO as noted in 14b above

d. What are the gaps in care coordination across the continuum of care?

- I don't have much to offer here.

15) RCCOs' roles in addressing cilents' and their families' non-medical needs. Please compiete the table beiow, keeping in mind adults, children, and famiiies:

- The RCCOs shouid focus on non-medicai systems only when these systems impact the health care of a Medicaid member. To take on the coordination of other systems would distract from the focus on heaithcare that this RFI/RFP seeks to address.

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☒	
Affordabiiity	☒	☐	☐	

(assistance with prescriptions or co-pays)				
Daycare / childcare	☐	☒	☐	
Economic stability & employment	☐	☒	☐	
Education	☐	☒	☐	
Environment	☐	☒	☐	
Food access / nutrition	☐	☐	☒	
Health literacy	☒	☐	☐	
Housing	☐	☒	☐	
Language or translation services	☒	☐	☐	
Literacy	☐	☒	☐	
Transportation	☐	☒	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) Requirements about who should be doing care coordination. Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☒	
Certified Addiction Councilors	☐	☒	
Certified Nurse Midwives	☐	☒	
Community Health Workers	☒	☐	Primary responsibly deepening on organizational structure.

Generaiists (BA/BS/MA/MS)	☒	☐	Primary responsibiy deepening on organizational structure.
Heaith Coaches	☒	☐	Primary responsibly deepening on organizational structure.
Licensed Clinical Sociai Workers	☐	☒	
Licensed Marriage and Family Therapist	☐	☒	
Licensed Mental Health Counselors	☐	☒	
Licensed Professional Counselor	☐	☒	
Masters of Public Heaith	☐	☒	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☒	
Nurse Practitioners	☐	☒	
Patient Navigators	☒	☐	Primary responsibly deepening on organizational structure.
Peer Advocates	☒	☐	Primary responsibly deepening on organizational structure.
Promotoras	☐	☒	
Psychiatrists	☐	☒	
Psychologists	☐	☒	
Registered Nurses	☐	☒	
Social Workers	☒	☐	Primary responsibiy deepening on organizational structure.
Wraparound facilitators	☒	☐	Primary responsibiy deepening on organizational structure.
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Popuiation	Specific	General	If specific, please describe
Newborns and infants	☐	☒	
Children	☐	☒	
Chiidren who are healthy, but in socialiy-compiex environments	☐	☒	I'm not sure how socially complex is defined.
Children involved in the foster care system	☐	☒	
Children with a chronic iliness	☐	☒	

Children with a serious emotional disturbance	☒	☐	Care should be coordinated by the BHO
Children with medical complexity	☐	☒	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	Care should be coordinated by the BHO
Transition-age adolescents	☐	☒	
Parents and families	☐	☒	
Pregnant women	☐	☒	
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☐	☒	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	Care should be coordinated by the BHO
Clients involved in the criminal justice system	☐	☒	
Clients with a disability	☐	☒	
Clients in a nursing facility	☐	☒	
Elderly clients	☐	☒	
Frail elderly clients	☐	☒	
Clients in palliative care	☐	☒	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

- The RCCO should only be involved if there are medical issues.

19) How should care coordination be evaluated? How should its outcomes be measured?

- Care coordination measures should monitor the reduction of duplicated care and the resulting reduction in medical expenses and the impact of this on health status.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

- This is very difficult to answer without actuarial analysis. The RCCOs may have a better handle on this. What is not advisable are rate cuts after the program has been implemented. This has

occurred in the RCCO program as well as the BHO program. These changes can be very disruptive to the successful implantation of effective program strategies.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

- Same as above.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

- It should vary by population but needs to be set by an actuarial analysis.

a. Care coordinator to client ratios. If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☒
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

- Cost of care – reduction in wasted care because of un-coordinated care. And the impact of this on health outcomes.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- I would agree with the iist provided above with the exception of provider contracts and payment mythologies. Provider contracting creates a competitive edge that saves money for the state and should be left to the RCCO to manage.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

- There is a danger in being too prescriptive in the RFP by requiring RCCOs to have certain community relationships. it would be better to have RCCO bidders describe the relationships they have and how they will enhance those relationships. Points should be awarded in the RFP for community relationships.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enroiled. Please comment on this proposal.

- i don't think this will work in rurai and frontier areas of the state. These areas don't have the popuiation needed to make this work.

27) Should the RCCO region maps change? Why or why not? If so, how?

- The state should go to fewer RCCOs and shouid consider combining RCCO regions 4 and 7. Most care in this part of the state is accessed through two major hubs, Puebio and Colorado Springs. Having these regions in one RCCO will make care coordination much more effective.

28) Shouid the BHO region maps change? Why or why not? If so, how?

- If the BHO maps were changed a new BHO RFP would have to be issued. i don't think the BHO maps can be change unless the state is ready to combine both (RCCO and BHO) programs. To change the BHO maps without combing the programs wouid be very disruptive to the BHO patients.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

- At least 6 months minimum would be needed.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

- Moving to risk contracts would make the ACC more effective and produce saving more quickly. Aliowing RCCOs to manage a PMPM for care I beiieve will show significant saving quickly. If quaiity measures are added to the deveiopment of the PMPM, I believe that care and access can also be positively impacted.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

- The addition of 9900 codes that allow integrated sights to provide services that are needed wouid be a major improvement.

32) Should there be muitiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. if so, why? if so, how many and where? What issues would this address?

- i don't think this can work in rurai /frontier Colorado, the population couid not support two RCCOs. 5ee question 26 above

33) if you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be wiliing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? if not, why not?

- N/A

34) What role shouid RCCDs play in attributing clients to their respective PCMPs?

- Don't have the information to answer this question.

35) What types of coilaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

- I am not aware of any.

36) What types of coilaboration should exist between the ACC Program and the Colorado Department of Human Servlces?

- N/A

37) What types of coilaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

- Medicaid is already a big enough task for the RCCOs; we should not put more on them.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

- DOi - only if there is a need for a license because of a risk contract.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

- There is a tendency to over burden programs with stakeholder processes and engagement that rarely produces any meaningfui outcomes. Most of the time outreach meetings are poorly attended with input coming from many of the same stakeholders who often provide input directiy.

I would suggest that the RFP allow bidder to propose a meaningful stakeholder process that works for their area.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

- See answer to Question 39.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

- This can be accomplished through the RFP awarding points for community involvement.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

- See question 39 above.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

- No
  a. if no, what are the gaps?

- Access to specialty care in rural/frontier parts of Colorado is a problem.

  b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

- I don't think the gaps are popuiation specific.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

- Hospitals across Colorado remain isolated from the broader health care provider community. They are often seen as the health care entity that consumes most of the health care resources and are entrenched institutions that are very difficult to change. The one encouraging exception to this is the Centura Health Neighborhoods movement. In this model Centura seeks to become a partner with health care entities across the state at the local level, where the impact is most keenly felt. If hospitals have a role in the RCCO it is because they have transformed into effective community partners, invested in managing health care resources.

b. What role should pharmacies play in the next iteration of the ACC Program?

- I don't see a role for pharmacies.

c. What role should specialists play in the next iteration of the ACC Program?

- Specialty care needs to be more accessible in rural/frontier counties. The ACC program should provide incentives to specialists to provide care in these areas. The expansion of tele medicine should be strongly encouraged.

d. What role should home health play in the next iteration of the ACC Program?

- Home health should be a central part of care planning. Hospitals should be required to work closely with home health agencies.

e. What role should hospice care play in the next iteration of the ACC Program?

- Hospice care should be readily available to all patients in the ACC program.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

- I don't know enough to answer this question.

g. What role should counties play in the next iteration of the ACC Program?

- This question is too broad.

h. What role should local public health agencies play in the next iteration of the ACC Program?

- Public heath agencies need to be an integral part of the referral resource for the ACC program.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

- HCPF should be cautious of over reaching and involving too many player in the ACC process thus making it burdensome to carry out the main mission of the program, deliver better, more coordinated care to a larger number of Medicaid members.

45) How can RCCOs help to support clients and families in making and keeping appointments?

- This will always be challenging but extensive outreach is the only approach that has worked for the BHOs

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

- No, this should be an option proposed by the respondents to the RFP. HCPF should be careful not to be too prescriptive in how the RCCO program should operate. Leaving room for communities to offer solutions should be a key theme of the RPF.

47) Community Health Worker reimbursement. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement should be at the discretion of the RCCO and should not be prescribed by HCPF in the RFP.

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

- The RCCOs should have a role in coordinating oral health. Oral health need to be a part of overall health care and needs also be integrated.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

- Good customer service that understands local customs and traditions.

b. What RCCO requirements would ensure cultural competency?

- The fallacy in this question is that requirements can drive cultural competency. I've yet to see this work in any real world setting. Asking bidders to describe the uniqueness of their community and how they see themselves addressing their need will give HCPF an insight into the bidder's ability to ensure culturally competent services. These values need to be ingrained in the organization's culture; no amount to requirements will drive these values if they aren't already there. HCPF should select bidders who can demonstrate this competency.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

- The skills must be driven by the values of the organization.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

- See 49 b. above

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

- This should be at the discretion of the RCCO to address region specific issues and should not be prescribed by HCPF.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

- The RCCO bid should reward the respondents for proposing programs and services that divert patients from emergency rooms for routine care. The bid should redirecting these recourse to the RCCOs to develop additional programs and services that keep patients from accessing expensive emergency room care.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) Support for practices. Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

- The state should avoid designing a one size fits all program for the ACC. While many of these tools, programs and services are useful and can work, it should be up to the bidders to make a case to HCPF on how these fit the specific community they work in and what benefit they believe can be derived from their use.

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☒	☐	☐
Network provider education	☐	☒	☐	☐
Assistance with practice redesign	☐	☒	☐	☐
Assistance with efficiency-enhancing activities	☐	☒	☐	☐
Provide web-based resources and directories	☐	☒	☐	☐
Provide practice-specific data reports	☐	☒	☐	☐
Provide clinical care guidelines and best practices.	☐	☒	☐	☐

Provide clinical screening tools	☐	☒	☐	☐
Provide health and functioning questionnaires	☐	☒	☐	☐
Provide chronic care templates	☐	☒	☐	☐
Provide registries	☐	☒	☐	☐
Offer client reminders	☐	☒	☐	☐
Offer client self-management tools	☐	☒	☐	☐
Offer educational materials about specific conditions	☐	☒	☐	☐
Supply behavioral health surveys	☐	☒	☐	☐
Supply other self-screening tools	☐	☒	☐	☐
Administer behavioral health surveys	☐	☒	☐	☐
Administer other self-screening tools	☐	☒	☐	☐
Prepare client action plans	☐	☒	☐	☐
Provide training on providing culturally-competent care	☐	☒	☐	☐
Provide training to supporting staff	☐	☒	☐	☐
Provide training on motivational interviewing	☐	☒	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☒	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☒	☐	☐
Provide referral and transitions of care checklists	☐	☒	☐	☐
Provide visit agendas or templates	☐	☒	☐	☐
Provide standing pharmacy order templates	☐	☒	☐	☐
Provide comprehensive directory of community resources	☐	☒	☐	☐
Provide directory of other resources	☐	☒	☐	☐
Provide materials regarding Nurse Advice Line	☐	☒	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☒	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

- N/A

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

- Rather than have requirements, have the bidders propose methods that would address this question.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

- Rate enhancements for participation in the RCCO program as defined by the RCCO in the bid response.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

- No

58) Please share any other advice or suggestions about provider support in the ACC.

- This section is very heavy on requirements. If these requirements are implemented as RFP requirements it leaves little or no room for creativity. it also shifts the success or failure from the bidder to the State. Winning bidder need only to focus on meeting the requirements to be successful rather than focus on solutions that meet the overall goal of population health.

  it would be better if the State allows bidder to offer solutions to improve population health and then monitor progress.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The RCCOs need to move to risk contracts that provide a PMPM that can be managed against goals for improved population health at a lower cost.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

- We are not primary care providers but our BHO has operated for 18 years by having providers take risk. Each of our Mental Health Centers operates on a Global Budget. We think this system of financing providers can work for primary as well.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

- No they are not. The biggest barrier is the fee for service system of reimbursement. The medical system in place currently is set up to generate volume not value, a fact that is known to anyone who has worked to reform the health care system. The biggest barrier is that there are no incentives for providers to move to a system that is based on value. In fact providers are penalized if they focus on value. The infrastructure will not be developed until the incentives for producing value are aligned with the payment structure. This transformation can best be achieved by introducing risk contract to the RCCOs that reward value rather than volume. I hope this can be done in the next RCCO bid.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

- Our organization is licensed by the DOI and we are ready and able to acquire any needed license and the required reserves. A license would not preclude us from bidding.

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

- RCCOs should be completely responsible for reimbursing providers they are required to manage.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Capitation payments (PMPM) with rate setting factors that reward quality

66) Measuring Client experience. Please complete the table below to indicate how the Department should measure Client/patient experience:

- The State should have broad measures of success for all RCCOs and should allow RCCOs to suggest additional measure that address local needs.

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	All of these should be options for measuring quality.
SF-12 Health Survey	☒	☐	
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☒	☐	
Focus groups	☒	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

- This needs to be the responsibility of the RCCOs but must be funded by the State.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

- Open and transparent though a website.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7 at most	☒
8-10	☐
11-20	☐

21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☒
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

- It should be a combination. Overall KPIs should address population health but allow for local indictors to address community needs.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

- Based on improvements

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

- The Department should not be constrained by the claims dilemma. RCCOs can develop the systems to monitor progress. These systems can be audited for accuracy to assure the State of their validity. To wait until the State can develop a system would waste valuable time.

74) Incentive payment frequency. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

N/A

75) For potential Offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

- I don't know the fixed costs of operating a RCCO but I do know the fixed costs of operating a BHO which might have some similarities. The BHOs are required to have access standards for routine, emergent and emergency care along with access to providers within acceptable driving distances. In order to meet these standards we have to over staff. This is one example but there are many such requirements in our current contract that drive cost. RCCO RFP requirements will drive fixed costs. That state should evaluate very carefully the whether these requirements will generate value to the health care system.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

- The BHOs are evaluated on 28 measures but reimbursement is not tied to any of them. We believe that these quality measures should be incorporated into the rate setting process for the BHOs. A similar process could be used to set RCCO rates if the state chooses, and we suggest they do, move to risk contracts.

Health Information Technology (HIT)

77) Types of communication. For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☒
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☐	☒
Smartphone app	☐	☒
Other:		

78) HIT investments by organizations. For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☒
Digital care management tool	☐	☒
Care transitions alerts	☐	☒
Electronic Health Records (EHRs)	☐	☒
Health risk assessment software	☐	☒
Practice assessment tools	☐	☒
Practice management tools (scheduling, billing)	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☒
Patient education/wellness tools	☐	☒
Provider/case manager directory	☐	☒
Shared decision-making tools	☐	☐
Telemedicine software	☐	☒
Other:	☐	☐
Other:	☐	☐

79) Importance of technology by type. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☒	☐
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☒	☐
Practice assessment tools	☐	☒	☐	☐	☐
Health risk assessment software	☐	☐	☒	☐	☐
Practice management tools (scheduling, billing)	☐	☒	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☒	☐	☐	☐

Patient education weliness tools	☐	☐	☒	☐	☐
Provider/case manager directory	☐	☐	☐	☒	☐
Shared decision-making toois	☐	☐	☒	☐	☐
Teiemedicine	☐	☐	☐	☐	☒
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technoiogy to improve the performance of Primary Care Practices?

- Staff feeling comfortabie with the technoiogy and rules for reimbursement is the primary barrier.

81) How can Health Information Technoiogy support Behavioral Heaith Integration?

- Information technology wiii benefit aii of heaith care with behavioral heaith being equaiiy impacted. The abiiity to reach out to rural/frontier areas wiii be of speciai interest to the rurai BHOs and RCCOs. CHP has invested heavily in tele-medicine for this reason.

  One chaiienge we are facing is the integration of medical information. There currently does not exist an electronic medical record (EMR) that can handle both primary care and behavioral health. This is a very big barrier to true integration. We are meeting this challenge through creative bridging of two EMRs but this is not an ideai solution. The expense of having to buy two systems may deter many providers from embracing the true impact that interstation can achieve. We are happy to share our experience.

82) In the next iteration of the ACC, shouid there be a shared resource for data and analytics? Piease describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

- Yes there should be a shared system for data and analytics. However, the state has been challenged to implement even a basic system of data sharing. i believe better results would be achieved if this task was given to the RCCOs and BHOs. The RPF should require that the contracting entities transmit anaiytics to the state rather than have the state develop a state wide system for data and analytics.

  The RFP could requlre that RCCOs track cost of care; health outcomes and other health outcome measure and be able to transmit these data in a common platform.

83) Should there be a shared care management tooi? Please describe the basic criteria for what a care management tool wouid need to contain in order for it to be useful.

- And effective care management tool must monitor access to care on a real time basis. Care managers need to know when appointments are made, prescriptions are filled and emergency rooms are accessed. Currently most care management is addressed after the fact and can oniy prevent future problems rather than intervene as duplicate and inappropriate care is being pianned.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

- This task should be the responsibility of the RCCO. The tool could look at the overall use of care by a population and identify duplicate and inappropriate care so that these trends can be addressed with the providers in the network. This arrangement works best under a risk model where providers are incentivized to be efficient.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

- The Connect for Health Colorado provider resource guide is a good model for such a directory. Members and care managers should be able to search for providers based on the needs of the patient.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

- The solution is clearly an effective CORHIO and QHN. Anything short of this would not be as effective.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

- A combined primary care – behavioral health EMR, the effective implementation of CORHIO/QHN with access for primary care providers and a real time system that tracks access to care.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

- The RCCOs in rural/frontier areas should be the primary source of HIT infrastructure. Most provider groups with the exception of hospitals and FQHCs cannot afford nor can they support the HIT systems needed. The RFP should accommodate this condition.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

- See question 86 above.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

- I have spent 6 hours working on this RFI. While it is very comprehensive, I am concerned that the task is so time consuming that the process will result in a low response rate.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 045

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

ACC Request for Information

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for information:

Please provide your name and location:

Name: Click here to enter text.
Location: City, County, State.

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Hospital Association
Location: Greenwood Village, Arapahoe County, Colorado
☒ **Please check if you are answering on behalf of this entity**

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

- ☐ Client
- ☐ Client's family member
- ☐ Client advocate
- ☐ Medical provider / PCMP / other provider
  - i. **Type or specialty:** Click here to enter text.
  - ii. **Area of practice:** Click here to enter text.
- ☒ Provider advocate (e.g. medical society)
- ☐ Potential bidder for RCCO contract
- ☐ Behavioral Health Organization
- ☐ Data or HIT entity
- ☐ Foundation
- ☐ Educational or research institution
- ☐ Another public or private program
- ☐ Legislator or elected official
- ☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

- ☒ Yes
- No
- ☐ I don't know

If you answered "yes" above, how long?

- ☐ Less than one year
- ☐ 1-2 years
- ☐ 2-3 years
- ☐ 3-4 years
- ☒ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:

As an organization, CHA continually monitors activities and progress of the ACC and RCCOs and provides feedback to HCPF, particularly in the areas of payment and delivery reform activities and how to engage our hospital members. CHA produced a Hospital/RCCO Summit in 2013, which brought together RCCO representatives from each region and case management directors from hospitals statewide. We are also an active participant on subcommittees of the ACC Program Improvement Advisory Committee and have been a member of the Medicare-Medicaid Enrollees Ad Hoc Advisory Subcommittee since it was formed in 2012.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

CHA represents 100 member hospitals and health systems throughout Colorado, all of whom are Medicaid providers. CHA partners with its members to work towards health reform and performance improvement, and provides advocacy and representation at the state and federal level. Colorado hospitals and health systems are committed to providing coverage and access to safe, high-quality and affordable health care. In addition, Colorado hospitals have a tremendous impact on the state's economic stability and growth, contributing to nearly every community across the state with 72,000 employees statewide. CHA actively monitors and works with HCPF on numerous areas of mutual

concern, including ACC, provider relations, and delivery and payment reform initiatives.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☒ N/A

While some of our members are existing or potential participants in the ACC, CHA itself is not.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

It has demonstrated its value, both via savings of taxpayer dollars and progress on key performance indicators statewide

2) What is not working well in the ACC Program?

CHA believes that while there is value in regional variation, the lack of unified processes and procedures places unnecessary strain on individuals and organizations (eg, providers) that interface with the ACC infrastructure. Additionally, we would like to see more outreach and education targeted at providers.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

CHA strongly values the state's commitment to integrating physical health and behavioral health (including mental health and substance use) and we would like to see higher levels of coordination both at the regional (e.g., BHO/RCCO) level and among providers, in order to provide improved patient-centered care.

4) What is not working well in the BHO system?

CHA has concerns that in the current system, there is a lack of accountability for care that is rendered and goes unreimbursed. The perception exists, and is validated in some settings, that a significant amount of unreimbursed care is being provided by a variety of providers (not just hospitals) – this care is being ethically provided by these various providers so patients do not go without the behavioral health services they need, often in times of crisis.

CHA would like to see increased transparency, financial accountability, and fiscal oversight of the BHOs. CHA is aware that HCPF is attempting to address these shortcomings and supports its efforts. Consistent with market trends and requirements included in the ACA, we recommend that HCPF consider amending department regulations to increase the medical loss ratio (MLR) applied to BHOs from the current 77% to 80-85% to assist

alignment with private market insurers (a majority of whom are now required to ensure parity for mental health and physical health services) and ensure effective and efficient use of state and federal resources. Finally, we would like HCPF to consider adding a neutral third party to the BHO appeals process in order to support impartial review of these appeals.

5) What is working well with RCCO and BHO collaboration right now?

For regions where RCCOs and BHOs are working together, the organizations have been able to identify shared issues and work toward solutions.

6) What is not working well with RCCO and BHO collaboration right now?

There is too much variability of RCCO-BHO partnerships, which is underscored by the lack of expectation and accountability at the state level for strong RCCO-BHO relationships and incentives to collaborate (or disincentives for lack of collaboration.)

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- Although CHA supports de-institutionalization as appropriate based on a patient's health condition, we would like HCPF to pursue regulatory options that allow Colorado to circumvent or modify the "Institutes for Mental Disease (IMD) Exclusion" in order to support better patient-centered care for individuals with severe mental illness.
- CHA supports increased transparency and accountability for BHOs and CMHCs, and requirements for coordination and collaboration with RCCOs and other providers in the local community.
- Currently, Medicaid clients with co-occurring mental health and substance use disorders have difficulty accessing services, especially for inpatient substance use disorder treatment, which often impacts their physical health as well. CHA supports removing regulatory and financial barriers to providing this necessary benefit.
- CHA believes that in order to successfully meet objectives outlined for integration of physical and behavioral health, HCPF must take a strong leadership role in developing and strengthening initiatives that build a behavioral health workforce adequate to meet the needs of Medicaid clients and the Colorado community. In addition to examining regulatory barriers to existing members of the behavioral health workforce in providing patient-centered care, this must include alignment of educational and employer objectives to train additional behavioral health workers.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services. Using the table below, please explain which issues are barriers, and how they can be addressed:**

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☒	☐	No Medicaid SUD inpatient benefit. Benefit should be created and funded.
Different behavioral / physical health reimbursement	☒	☐	
Institutions for Mental Diseases exclusion	☒	☐	Non-use of empty psych beds due to IMD – more units closing. Although exclusion is at the federal level, HCPF could pursue state-only funding to circumvent this barrier.
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	Regulatory and financial discrepancies and redundancies across agencies needs to be addressed. Licensing rules at CDPHE and OBH rules are inconsistent with each other.
PCMP financing structure	☒	☐	As this relates to future ACC program changes, hospitals and health systems need to be part of the overall financing dialogue in order to ensure access to care, both for primary care (to the extent primary care is offered in many hospital-based settings) and for emergency, acute, and specialty care.
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

	ACC Request for Information		
RCCO or BHO contracts	☒	☐	Both contracts should have consistent requirements for fiscal oversight and accountability, benefits and reimbursement policy should be aligned, and RCCO-BHO collaboration and cooperation should be required and/or incentivized.
Staff capacity	☒	☐	See response to #7 above.
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others			

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

HCPF should consider whether a provider is genuinely capable of providing not only physical healthcare, but also mental health services and substance use services. Although mental health and substance use disorders are generally lumped under the "behavioral health" heading, it is important to remember that the care – and provider types – generally differs between the two.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

The statistics on comorbidities – not only of physical and behavioral health, but also of mental health and substance use – is astounding. According to the National Alliance on Mental Illness (NAMI), 50% of adults with mental illnesses have a lifetime substance use disorder, and less than 50% of individuals referred from a primary care provider to a behavioral health provider make it to their first appointment. As such, integration is critical to the success and sustainability of Colorado's health system.

Medicaid's top priority for integration must be addressing benefit coverage, payment policy, licensure, and other regulations that impede care for mentally ill individuals with co-occurring substance use disorders. Without addressing this challenge, access to care designed to prevent avoidable costs "down the road" – such as emergency care and crisis mental health service costs – will be thwarted.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

b. How should RCCOs prioritize who receives care coordination first?

While CHA believes that care coordination services should be provided to all Medicaid beneficiaries, we also believe the department should prioritize reforms that address the needs of high need/high cost beneficiaries (e.g., aged, blind, disabled individuals and individuals with behavioral health comorbidities).

Research has shown that certain populations benefit the most from care coordination. CHF, diabetes mellitus, severe mental illness, recent stroke, and high utilizers of certain area of the delivery system have the best potential for reducing costs and utilization whlle improving the outcomes for patients.

c. How should RCCOs identify clients and families who need care coordination?

Data analytics can provide insight into defined populations that can benefit the greatest.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

Develop standardized care coordination tools at the State and RCCO level.

Invest in health information technology and exchange, particularly for providers not otherwise eligible for federal incentive payments.

12) What services should be coordinated and are there services that should not be a part of care coordination?

Facilitate coordination across the entire care continuum, including through a more defined and expanded role for hospitals in RCCOs' networks and strong coordination with social services where needed.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

Hospitals use hospital staff or volunteers (called navigators, discharge advocates, coaches, etc.) to either call patients at home after discharge or visit patients at home after discharge to assure that the patients have the information and resources they need to successfully care for themselves at home. The coordinators often focus on a specific population, such heart failure patients, total hip/knee replacement patients, those at higher risk for post-discharge complications, or those whose health improvement is heavily dependent on post-discharge treatment (eg, physical therapy) or patient behavior (eg, drug adherence). The staff in this role can access medical record information from the hospital to provide specific information to the patient, such as information about the medications prescribed for the patient at discharge.

Some hospitals use navigators to help patients navigate the healthcare system when they will need on-going care from a variety of providers. An example is a navigator for people with breast cancer. The large third-party payers also have coordinators who call patients at home to check on their status and respond to questions.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

Care coordination should be invisible to the client and also patient-centered. Patients should not be responsible for coordinating the care coordinators. All Medicaid contractors could be required to coordinate services among themselves or RCCOs could be held accountable for developing a care coordination partnership within their region.

d. What are the gaps in care coordination across the continuum of care?

There is lack of communication and miscommunication among care providers (hospital, physician, home health agency, hospice facility, long-term care facility, etc.) regarding the on-going plan of care. Much of the communication is via paper or electronic forms. This can limit understanding of the nuances of the care needed by a particular patient. In urban hospitals, the physician caring for the patient is often not the patient's PCP, and this can lead to miscommunication opportunities. This also highlights the need for care coordination tools – such as a client case management tool – at the state level.

1S) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☒	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☒	Coordinate with hospitals for patient education and engagement for populations receiving hospital-based services.
Environment	☐	☐	☐	
Food access / nutrition	☒	☐	☐	
Health literacy	☒	☐	☐	Understanding health literacy and how to successfully communicate with clients.
Housing	☒	☐	☐	
Language or translation services	☒	☐	☐	

Literacy	☐	☐	☐	
Transportation	☒	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) Requirements about who should be doing care coordination. Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Counciiors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☒	☐	Coaching and education after hospital discharge
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	Primary care
Nurse Practitioners	☒	☐	Primary care for people with less complex illness
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	

Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Please type your response here. Any and all of these different providers might have a role in care coordination – it all depends on what the care and navigational needs of the patient are and what resources are available in a given community.		

17) Care coordination requirements for specific populations. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☒	☐	They often need care over many years, so long-term coordination is important.
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☒	☐	See above.
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	

Frail elderly clients	☒	☐	Frail elderly clients who live alone and lack adequate social support are at great risk of harm.
Clients in palliative care	☐	☐	
Other populations, please comment: All of these patients might require care coordination services, and they might not; again, dependent upon the patients care and navigational needs and local resources.			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

A developed risk adjustment system similar to the Medicare Advantage system adjusts payments to the level of costs of providing care. The cost of care management may correlate to the cost of delivering care and be an appropriate schedule.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

Metrics that measure quality of care and health outcomes are most valuable, with lower emphasis placed on reducing utilization and cost. Quality and outcome metrics should include functional assessment of the client. Once good results are available for quality, then utilization and cost metrics can change.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Care coordination is only effective if Medicaid recipients are engaged and accountable for following treatment plans. Care coordination must be designed with member accountability in mind AND the care coordination services being designed so that the services "meet the client", not the other way around as has been much of the current systems set up.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

Regardless of which region maps change, it would be ideal for RCCO and BHO regions to be identical. This would help facilitate better care coordination, consistent community outreach, and alignment of regional interests.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

Fund and create a benefit for inpatient SUD treatment. This could be achieved by funding treatment with state-only dollars or engaging with HHS on exemption or waiver options to modify the IMD requirements. Managed care contractors – such as BHOs - should be audited regularly, and medical loss ratios should be raised to at least 80%.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

They limit access to services by barring comprehensive treatment of co-occurring mental and substance use disorders. Also, there needs to be an intermediate (between contractor and ALJ level) BHO claims appeal/review process using a neutral third party.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

HCPF and CHDS should conduct a thorough analysis of behavioral health regulations, benefits, and services and engage in a wholesale redesign of behavioral health regulation to eliminate conflicts and redundancies and create a more logical regulatory approach. State agencies should "model the way" of integration by integrating the administration of physical and behavioral health benefits and services at the state level.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

HCPF and DOI should identify consistent methodologies and standards for measuring and enforcing network adequacy.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

While moving toward integrated care for ACC clients across the state, the department should bear in mind that there is a shortage of primary care providers and behavioral health providers in rural and underserved communities, and that incentives designed to support regional integrated care settings (such as community mental health centers), may have the unintended consequence of impeding access to primary care.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

No.

a. If no, what are the gaps?

There are gaps in specialty services, which are not available statewide for everyone. For example, there is a critical shortage of behavioral health workers and access to inpatient behavioral health treatment.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

Entities a-e listed below are all providers of care and, as such, should be partners in the development of the next iteration of the ACC Program.

a. What role should hospitals play in the next iteration of the ACC Program?

The ACC program today is focused on primary care, including care coordination and integration between physical and behavioral health. Hospital services – both inpatient and outpatient – are a critical part of the care continuum in every region and account for the largest portion of Medicaid spending in Colorado.

Most of the key performance indicators for the ACC program depend upon changes in hospital-based practices, such as hospital admissions and readmissions, high-cost imaging, and emergency department (ED) utilization. Therefore, hospitals have the potential to play a stronger role in achieving the Triple Aim in the ACC and need to have a greater role in the development of the ACC and RCCOs at both the state and regional level. True care coordination can only occur if hospitals inpatient and outpatient areas are included in the reporting of data and real time access to data. Additionally, hospital organizations may be a reliable source of care coordination in some communities because of the integration of physicians, hospital, residential, and other post-acute care providers.

We strongly encourage RCCOs to consider the value of adding a hospital representative to their governing board and stakeholder groups in order to take advantage of the valuable resources hospitals provide to Medicaid clients.

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

RCCO care coordinators should be required to closely navigate relationships with these agencies for ACC clients in order to ease the patient's burden of navigating the bureaucracy of multiple organizations. This is especially necessary for populations with co-occurring, complex, or chronic conditions and those whose behavioral health needs create additional challenges.

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

Perhaps the biggest challenge for LPHAs and the ACC is that there is significant variation in the scope of services LPHAs provide. As a general rule, LPHAs should work closely with RCCOs and providers to support improved population health. LPHAs that provide clinical care should be part of the care coordination system.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

Patient engagement and education is key to achieving better health outcomes. While there are legal constraints on some methods for Medicaid to build client buy-in (e.g., through prohibitions on client cost sharing), HCPF should consider the viability and efficacy of client engagement incentives, for both providers and clients.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

There should be some type of navigation support available in the community. This would need to be coordinated with the local hospital(s) and others who may already provide such services. Reimburse lower cost care navigators/community health workers to help educate patients and involve them in the development and adherence to care plans

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☒

On staff (salary) at Primary Care Medical Provider Clinic	☒
On staff (salary) at RCCO	☒
Per Member Per Month Payment	☒

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

RCCO care coordinators should be required to closely navigate relationships with dental providers for ACC clients because navigating multiple systems creates additional barriers to care, particularly for clients with multiple concurrent conditions.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Emergency room utilization is lowered through efforts before the patient arrives at the emergency room. Proactive coordination that bonds patients to PCMPs, and breaks through barriers to seeing the PCP have the best effort of addressing the trend. RCCOs should be responsible for calling patients, assisting patients in understanding information needed, scheduling appointments, and ensuring transportation.

The delivery system needs to be easily understood by the patient and not require the patient to "figure out" the system.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Consider providing capacity-building incentives to PCMP offices that agree to see patients in the evenings and on weekends.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☒	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☒	☐	☐	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☒	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☒	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others	Comment: The Department should acknowledge that needs for these supports will vary across the state and even within communities. Items checked above are all valuable for providers; the need will vary from provider to provider. As a general principle, state tools should not be overly			

prescriptive, as some providers may have similar tools in place already. To the extent possible, tools should be interoperable with other complementary tools or platforms.

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

A specific tool should not be required unless it has been nationally proven to be a valid and reliable tool across large populations and across a wide variety of provider types.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

Not sure how this would be helpful. Disease registries have historically served clinical or public health research, not individual clients or providers. If this were required of PCMPs, the Department would need to provide reimbursement to PCMPs for data entry to such registries, as it typically takes dedicated staff to successfully participate in data submission. That money would be better spent on patient care and services.

58) Please share any other advice or suggestions about provider support in the ACC.

All providers, including hospitals, who meet the criteria should be able to serve as Medical Homes to ensure engagement of the providers from whom patients' get the majority of their care.

Continue and strengthen State support for rural workforce development and incentives (expanded to include specialists and hospital administration), broadband connectivity, and telehealth capacity.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

CHA does not have a position on whether RCCOs should have a more significant role in financial distribution or payment reform strategies within the ACC. However, if RCCOs take on added financial responsibility, risk, or decision-making functions, additional safeguards must also be added to ensure accountability for funds used and maintenance of quality and access standards. This could include audit and MLR functions, among others.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

Reimburse providers who are not serving as Medical Homes for care coordination services that are not covered through fee-for-service reimbursement.

Reimburse providers for care coordination, care transition, transportation, and telehealth services, which will help beneficiaries access care in the most appropriate settings. Reimbursable telehealth services should include email and telephone consults.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

Hospital admission rates and readmission rates for certain chronic conditions (adult and pediatric), low birth weight rate, process measures that reflect standardized processes (e.g., regular eye exams for diabetic patients). Generally, performance metrics tied to payment should have a strong evidence base that supports the metric's accuracy and the efficacy of methods to meet quality or outcome standards.

66) Measuring Client experience. Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

Outcomes data should be reported to PCMPs comparing the PCMP to other PCMPs (blinded).

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) Incentive payment frequency. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) Types of communication. For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) HIT investments by organizations. For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) Importance of technology by type. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☐
Care management tool	☐	☐	☐	☐	☐
Care transitions alerts	☐	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☐
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

81) How can Health Information Technology support Behavioral Health Integration?

By having a unified system at all points where clients access services, care coordinators could monitor clients' entry into the system, delivery of services to clients and utilization patterns. Telehealth can also be integrated into primary care settings – as it already is in parts of the state – to provide behavioral health services.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

Yes. See first sentence of response to question 81 above.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 046

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Sue Williamson
Location: 6130 Greenwood Plaza Blvd, Ste, 150, Greenwood Village, CO 80111 (Arapahoe)

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Signal Behavioral Health Network
Location: 6130 Greenwood Plaza Blvd, Ste. 150, Greenwood Village, CO 80111 (Arapahoe)
x Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
X Other (please describe): Managed Services Organization

Are you currently involved in the ACC program?

☐ Yes
x No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Signal has a contract with Foothills Behavioral Partners, one of the Medicaid BHOs, to assist in facilitating the contracting/compliance/quality assurance of substance use providers with Foothills

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
X Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Signal would very much like to participate in the RCCO program to help facilitate and inform the delivery of substance use disorder treatment services based on its expertise in managing a network of SUD providers. However, under the current structure, Signal has limited participation through a contract with one of the State's BHOs.

☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

Our knowledge is limited based on information shared with us through Department newsletters and other public forums.

2) What is not working well in the ACC Program?

Insufficient information to comment

What is working best in the Behavioral Health Organization (BHO) system right now?

Insufficient information to comment.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

Insufficient information to comment.

4) What is not working well in the BHO system?

Many of the SUD providers within the Signal network are experiencing significant challenges in the contracting process with the BHOs/Value Options. There has been general confusion on credentialing/licensure issues; on which codes to bill, etc – general administrative barriers. Our providers report substantial delays in getting reimbursed. In fact, several of our providers have been waiting to receive reimbursement since January 2014.

Additionally, Colorado's SUD system is experiencing workforce shortage areas, particularly in the rural areas. Some barriers to hiring new staff include long wait times for licensure approval, reimbursement rates that don't all for the ability to hire or provide pay increases for these professionals and limits in loan repayment programs for this workforce.

State data systems and the lack of actionable information remain problematic. Because of the federal regulations relating to the privacy rights of those seeking SUD treatment, the RCCOs may not have access to the complete patient record.

Existing and separate data systems between HCPF and the Office of Behavioral Health (OBH) as well as the complexity of braiding funding for Medicaid clients for services not covered by Medicaid represent a challenge to providers in determining what appropriate payer source to use for a particular patient. Additionally, the Medicaid "churning" issue where patients gain and lose Medicaid eligibility creates tremendous administrative and financial barriers for providers and more importantly, creates significant access issues for patients.

5) What is working well with RCCO and BHO collaboration right now?

Insufficient information to comment.

6) What is not working well with RCCO and BHO collaboration right now?

Insufficient information to comment.

Behaviorai Health integration

7) What shouid be the next steps in behaviorai heaith integration in Colorado?[1]

Extensive analysis and mapping of the components/goals of the State innovation Model (SIM) grant against the vision and goais for the integration of physicai and behavioral health must occur to assure administrative, financial, data, provider and client needs are aligned. We encourage the Department to continue to explore expanding the current Medicaid SUD benefit to ensure that Medicaid clients have access to the fuii continuum of SUD services. The management of the SUD benefit by the BHOs contlnues to be a work in progress. As previously mentioned, SUD treatment provlders have experienced signiflcant barriers in contracting with the BHOs, in the billing process and in receiving timeiy reimbursement. In fact, many SUD treatment providers have been required to hire additionai billing staff to navigate the new heaithcare environment in which Medlcaid now plays a more prominent roie. It is our understanding based on information shared in community meetings that the penetration rate of those Medicaid patients recelving SUD treatment services is relatively iow in certain BHOs and in certain areas of the state.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	X	☐	
Community Behavioral Health Services Rule	X	☐	
Covered diagnoses list	X	☐	
Different behavioral / physical health reimbursement	X	☐	
institutions for Mental Diseases exclusion	X	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	X	☐	
PCMP financing structure	X	☐	
Per-member per-month amount	X	☐	
Physical space constraints	X	☐	
Privacy Laws (HIPAA, 42 CFR)	X	☐	
Professional / cultural divisions	X	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	X	☐	
State/Federal rules or reporting requirements	X	☐	
Technical resources / data sharing	X	☐	
Training	X	☐	
Others	This is complex work that requires a thoughtful approach and implementation. Priorities		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

should be established in terms of mitigating or eliminating the barriers over a period of time. To move too quickly without a sound plan will have the potential of eroding the progress and goals of the ACC and will serve to frustrate providers, payers and clients. We strongly recommend an incremental and methodical approach to integrating behavioral and physical health as has been done with the original RCCO implementation.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

Long-term, we need to think of integrated whole-person care beyond the "4 walls" of a clinic. We need to create a system of community-centered health homes to improve the health and safety of the members of a community. We need to improve the integration and coordination of preventive services between public health, primary and behavioral health and community settings. Only by promoting positive health behaviors for individuals and truly engaging the patient or caregiver to be part of the care team and share decision making will we truly achieve the goals of the Triple Aim and whole-person centered care.

Most immediately, SAMHSA and HRSA for integrated Health Solutions has developed a framework for levels of healthcare integration which describes the key elements for each level of integration which seems would be a good starting point.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

The financial mechanism is going to be critical. At this juncture in time, there are a number of ancillary activities/services that behavioral health providers offer and provide that are critical to ensuring that the patient receives the right care at the right place and the right time. Often times, providers are unable to receive reimbursement for these services. If you keep the patient/client at the focus of your efforts, you can create a healthcare delivery system where individuals and families have the knowledge, ability, resources and motivation to identify and make healthy choices and are empowered to manage and organize their own care at the level they choose.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

Because all healthcare is local, there is not necessarily a "best" definition of care coordination. Care coordination is going to look differently in every community based on the resources and needs of a given community. Payment models should support patient navigators, care coordinators, health coaches and community health workers that support individuals both in and out of the office setting.

b. How should RCCOs prioritize who receives care coordination first?

This should be informed by the data within a particular RCCO based on the demographics and needs in the particular region.

c. How should RCCOs identify clients and families who need care coordination?

The analysis of all available data is critical. If it's not already happening, the RCCOs should avail themselves of the community needs assessments completed by the local public health departments to help inform these discussions.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

No answer

12) What services should be coordinated and are there services that should not be a part of care coordination?

No answer

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

Use existing data and ask the individual/client to identify their needs – the answers may surprise providers.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

A mixture of duplicative services and ongoing gaps for certain populations.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

The majority of behaviorai healthcare provides (inciuding SUD providers) are coordlnating care that includes a human services component (eg housing, transportation, community services and programs). For those clients recovering from addiction, this care coordlnation is critical to promote the long-term recovery for those clients.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

An assessment and mapping of the current care coordlnation relationships is critlcai to avoid duplication and identify gaps.

d. What are the gaps in care coordinatlon across the continuum of care?

While critical to a client's long-term recovery, 5UD providers often lack the necessary resources to deilver care coordination for an extended perlod of time. As previously noted, the care coordination often includes the interaction of human services agencies and other community supports and programs to support the client's recovery and overall health.

15) RCCOs' roles In addressing clients' and their families' non-medical needs. Please complete the table beiow, keeping in mind aduits, chlldren, and famiiies:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☐	
Affordablllity (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	
Health iiteracy	☐	☐	☐	

Housing	☐	☐	☐	
Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	
Transportation	☐	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	

Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound faciiitators	☐	☐	
Other	Please type your response here.		

17) Care coordination requirements for specific populations. Please use the tabie below to describe if any of the foiiowing populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	if specific, piease describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Chiidren involved in the foster care system	☐	☐	
Chiidren with a chronic illness	☐	☐	
Chiidren with a serious emotional disturbance	☐	☐	
Chiidren with medical compiexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adoiescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-compiex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behaviorai health diagnosis or substance use disorder	☐	☐	
Clients invoived in the criminal justice system	☐	☐	

Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

No answer

19) How should care coordination be evaluated? How should its outcomes be measured?

No answer

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

No answer

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

No answer

a. Care coordinator to client ratios. If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐

1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

No answer

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Allow for flexibility within the framework to meet the needs of the providers, clients and communities. The ultimate long-term outcome should be that clients receive safe and effective care that is coordinated locally, using statewide resources when necessary, from a team of appropriately trained healthcare providers.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

To the extent possible, consistent data reporting is critical to ensure that similar activities and services are similarly measured to identify best practices across the board and to effectively measure health outcomes and corresponding costs.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

The RFP should include a section where the RCCO has to include a community engagement plan that identifies its outreach efforts in established productive collaborations and relationships within the community.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

No answer

27) Should the RCCO region maps change? Why or why not? If so, how?

It is my understanding that the original RCCO maps were devised so there would be an equal number of covered lives in each region. The RCCO maps should be changed to the extent that they accurately represent the natural occurring geographic ways in which clients access care.

28) Should the BHO region maps change? Why or why not? If so, how?

It seems the goals of integration would be better achieved if the BHO/RCCO maps were aligned. Any geographic divisions should reflect the patterns of how clients access services to promote better health outcomes and to leverage existing provider and community relationships.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

No answer except to say that sometimes government does not have the best track record of operationalizing policy or new programs, so implementation should be deliberate in order to achieve optimal success.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

Some of the legislation and policy changes need to happen at the Federal level. Any alignment of rules between the different state agencies impacted would be advisable.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

Expanded substance use disorder benefits. It is complicated for providers to both bill Medicaid and use their block grant indigent dollars to fund non-covered Medicaid services.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

Only if it promotes greater access for clients and improved health outcomes.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

No answer

34) What role should RCCOs play in attributing clients to their respective PCMPs?

To the extent it promotes the continuation of an established medical home between the provider and the PCMPs and promotes greater access and improved health outcomes, the RCCOs may have an appropriate role to play.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

The ACC Program and CDPHE should identify ways to strengthen prevention efforts within the RCCO structure.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

The ACC Program and CDHS need to collaborate to ensure that Medicaid funds and OBH funds are appropriately paying for services. Better collaboration is needed to ensure that OBH funds continue to be used for those people who need behavioral and SUD services not covered by Medicaid. Additionally, collaboration can promote identifying and using resources that address the social determinants of health which are the real drivers of health and healthcare costs.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

No answer

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

The ACC Program should work with DORA to modify licensure processes that currently slow the movement of qualified licensed healthcare professionals to Colorado from other States. Additionally, a review of the

current licensure provisions should be undertaken to expand the ability of behavioral healthcare specialists to work in an integrated care setting.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

Ongoing, extensive and meaningful participation by clients and their families and client advocates is critical in obtaining the buy-in of the community. The RCCOs should have plans on how they are going to make the client experience more "client-focused" with true client engagement and how they are going to make the delivery system less fragmented and easier for clients to access needed services.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

A very detailed plan by any RCCO bidding should be required as part of the RFP process.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

Through authentic, meaningful, culturally-sensitive, consistent and intentional outreach.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

The Department should demonstrate how it incorporated the feedback from stakeholders to improve the client experience and access within the RCCOs.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

There is currently a workforce shortage of behavioral health practitioners in Colorado, especially in rural areas of the State. We need to identify the regulatory and administrative barriers that contribute to the workforce shortage.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

No answer

45) How can RCCOs help to support clients and families in making and keeping appointments?

improve the NEMT transportation component and continue to work on training staff to treat Medicaid clients in a respectful and non-judgmental way knowing that Medicaid clients are some of our most vulnerable members of the community and have a litany of issues of life besides their healthcare that contribute to missed appointments and non-compliance.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

It should let the local communities determine the most appropriate deployment of workforce to meet its needs.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

No answer

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Bidders should be expected to demonstrate that they or their community partners can provide services in a culturally-competent manner.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

Possibly and would need more information on the Department's thinking in order to provide an informed response.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Many of the clients accessing emergency rooms have co-occurring conditions involving both physical and behavioral health/substance abuse issues. The ACC should use the data to identify those clients utilizing the emergency room on a regular basis and implement a more intensive case-management program to work with these clients.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

No answer

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

For many SUD providers, especially the smaller providers, the transition to Medicaid has been challenging. I would recommend that RCCO's work with the Managed Services Organizations (MSOs) to assist with the practice transformation for these providers.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

Incentivize providers through true performance-based contracting, not contracts that withhold funds from a provider before the provider has had an opportunity to perform the services.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

Yes

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

No answer

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

No answer

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

The SUD provider network that serves the State's indigent clients is an underfunded system and providers have never been paid their costs for providing critical SUD treatment services. Nonprofit SUD provider agencies have had to subsidize their operations and infrastructure by identifying outside funding sources to support their infrastructure costs. If the block grant funds could be used to improve and fill the gaps within the existing infrastructure, SUD providers would be in a better position to consider this approach.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

No answer

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

No answer

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

No answer

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

No answer

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

By integrating other sources of data, like registries, with the claims data.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

CIVHC or CHI could provide guidance on this.

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Yes and no. I could envision a system where there would be certain baseline KPIs for all RCCOs and other KPIs established in each of the regions based on the needs and health status of clients in a given community.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

No answer

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

No answer

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

No answer

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

No answer

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) Importance of technology by type. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☐
Care management tool	☐	☐	☐	☐	☐
Care transitions alerts	☐	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☐
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Federal privacy regulations related to the sharing of SUD information. HIT is incredibly expensive and implementation requires a long-term commitment and the realization of loss of productivity during the implementation phase.

81) How can Health Information Technology support Behavioral Health integration?

Dissemination and exchange of data with external providers, health systems, and other stakeholders can enhance care coordination and care accountability.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

No answer

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

No answer

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

No answer

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

No answer

86) How can the RCCOs support providers' access to actionable and timely clinical data?

No answer

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

Technology will be able to support patient engagement and patient activation and the State should have dedicated resources to provide these tools for clients.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

No answer

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

They need to play a critical role. The EHR systems that behavioral health providers use are quite different than used by the physical healthcare providers and there needs to be an entity that facilities the exchange of information between all of the divergent systems.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 047

Accepted by: KJDW

Notes: Standard cover sheet added;

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

ACC Request for Information

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Annette Rosling, MD

Location: Grand Junction, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Western Colorado Pediatric Associates

Location: Grand Junction, CO

☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty:
  ii. Area of practice: Pediatrics
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

Are you currently involved in the ACC program?

How have you been involved in the ACC program and what interaction have you had with RCCOs:

I provide medical care for children enrolled in an RCCO

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

I provide medical care for children with Medicaid.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☒ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

☒ Yes
☐ No
☐ I don't know

Please feel welcome to describe why or why not using the space below.

If you answered "yes" above, how long?

☐ Less than one year
☒ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.

- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.
    - So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
    - Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
    - There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing SDAC data is just one way to understand the activities within a medical home. SDAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients
  b. Telephone consultation by a child psychiatrist to primary care providers
  We recommend that BHOs be required to provide the 2 components above as part of their new contracts. The program also needs to be expanded to cover the entire state.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Care Coordinotian

Question 12) Whot needs for children/fomilies should be coordinated in medicol homes and are there services thot should not be o part of core coordination by the pediatric and family medicol home

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Our medical home relates to multiple RCCOs and we want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we could receive a pmpm from all of them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where shauld care coordinotion be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill? The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care

coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County
- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

- Since children are the majority and give the best chance of truly improving health and wellness, KPIs need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

<u>There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully.</u> Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and provider from medical homes to develop a vetting process that will enable HCPF and RCCOs to trust medical home self-reported real-time data.

- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd.
  Appropriate child health measures could be selected from the following measures :
  - Well child visits appropriate for age
  - Developmental screening by three years of age
  - Teen depression screening
  - Complete immunization status by age two
  - Post-partum depression screening rate for mothers of newborns by age 4 months
  - Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
  - Patient (or family) satisfaction ratings
  - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of
Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 048

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Arnold Salazar
Location: Alamosa, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Health Partnerships
Location: Western/Southern CO
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Behavioral Health
  ii. Area of practice: Behavioral Health
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☒ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Mind Springs works very closely with Region 1 and has been instrumental in developing the concepts used for 1281.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Behavioral Health provider covering 10 counties: Eagle, Garfield, Grand, Jackson, Mesa, Moffat, Pitkin, Rio Blanco, Routt, and Summit

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Program is close to the community and allows local solutions to be developed. Having multiple RCCOs sharing these solutions with each other will have greatest impact.
- Focuses on local solutions – must be customized to meet local needs.

2) What is not working well in the ACC Program?

- Payment reforms are moving too slow to have significant impact on cost and quality of care. We are still largely tied to a fee for service system that is volume driven and not focused on quality outcomes. The question of how to transition provides away from Fee for Service and on to payment for quality has eluded almost everyone. While KPIs have been tried and have had some impact, they can have only limited impact on cost. A risk model that focuses on cost as well as quality and access will prove to be a much more effective reform tool. Additionally, much more attention is needed in the area of special populations such as those with DD or SPMI.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

- The BHOs have been able to control costs over a long period of time while providing access to more members. BHOs have figured out how to manage provider risk which must be a key component of any payment reform initiative. Additionally, through the CMHC contractors, there now is a robust continuum of care for Medicaid individuals.

4) What is not working well in the BHO system?

- The payment structure over time has moved too much toward encounter reporting which has its roots in Fee for Service. HCPF has not been able to move to outcome based reimbursement which is strongly suggested to be the end goal.

5) What is working well with RCCO and BHO collaboration right now?

Locally in Region 1 there is awesome BHO/RCO/CMHC/PCP collaboration. It is believed to be the only area that has this level of partnership and innovation. This must be supported and even rewarded.

6) What is not working well with RCCO and BHO collaboration right now?

Progress toward payment reform is much too slow. SDAC data is still not being shared with the BHOs at a level that could help coordinate care in a much more effective manner.

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The RCCO RPF should encourage integration. Bidders should be rewarded with higher scores for closer integration of programs, data and finances.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	Barrier? No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☒	
Community Behavioral Health Services Rule	☒	☐	Paperwork still needs to be streamlined.
Covered diagnoses list	☒	☐	It would be much easier to integrate if we did not have a limited diagnosis list; however I understand the cost implications of opening this up to all diagnosis and codes. Need to open up the integrated care codes for the next RFP to be successful.
Different behavioral / physical health reimbursement	☒	☐	Payment reform needs to move faster
Institutions for Mental Diseases exclusion	☒	☐	Although this is an issue, the 1915 (b)(3) waiver offers some flexibility through the Medicaid Managed Care program.
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	While this has improved, much more work needs to be done to streamline if integration is to occur. 42 CFR is a major issue as well
PCMP financing structure	☐	☐	I don't understand this well enough to comment.
Per-member per-month amount	☐	☒	However, the focus needs to be on outcomes, not encounters and FFS
Physical space constraints	☐	☒	
Privacy Laws (HIPAA, 42 CFR)	☒	☐	42 CFR is a real problem with care coordination, HIPAA however is not an issue.
Professional / cultural divisions	☒	☐	This is one of the many challenges we have found. The BHO and MHCs have some very rich experience in this area.
RCCO or BHO contracts	☐	☒	
Staff capacity	☒	☐	Staff capacity is an issue for all of health care in Colorado. BHOs and MHCs face those same challenges.

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

State/Federal rules or reporting requirements	☒	☐	The reporting requirements need to be aligned.
Technical resources / data sharing	☒	☐	SDAC data needs to be shared with the BHOs
Training	☐	☒	
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

- We think that the six levels of integration best reflect what we need in the field.

  http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

- The deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services

b. How should RCCOs prioritize who receives care coordination first?

- I don't think that care coordination can be prioritized. To do so may ignore minor problems that can escalate. Sometimes our most effective care coordination prevents the escalation of health problems. I would caution against prioritizing.

c. How should RCCOs identify clients and families who need care coordination?

- Care coordination should occur at the primary care (bi-directional) level for anyone accessing more than one health care system.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

The model used on the western slope is an example of great partnership between PCP and CMHC in delivering care coordination activities jointly. CMHC staff are a part of the PCP medical team. This utilizes the strength of each organization and the end result is better.

12) What services should be coordinated and are there services that should not be a part of care coordination?

- All services should be coordinated including services outside the medical visit that impact the health care of the Medicaid member; including Social Services and Public Health .

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

- Care coordinators need to know how patients access primary care including bi-directional service locations,(locations where behavioral health clients receive their primary care.) All care for specialty should be accessed through the primary care provider and should be coordinated by the RCCO. Care coordination is both an individual issue and also an organizational issue. There must be incentives for both levels of coordination. The 1281 project being done on the western slope is an example of this

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

- Care coordination is happening at all levels which is part of the problem. The RCCO bid should seek to consolidate this process and reward bidders for identifying and then developing systems that address the issue of multiple care coordination systems. Additionally need to support organizational alignment for care coordination

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

- BHOs are required to coordinate care for Behavioral Health patients. This sometimes can be in conflict the care coordination required by the RCCOs. Colorado Health Partnerships through its Mental Health Center providers has worked to make this an effective process. I believe this could be used as a model for how other system of care coordination is brought under the RCCO process. We have a care coordinator community meeting that is helpful on the western slope

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

- By assuring this question is addressed, but allowing local solutions

d. What are the gaps in care coordination across the continuum of care?

I think the biggest gap is too many involved and not enough coordination of the coordinators. Again, local solutions can address this. It is also important to use strengths and core competencies. RCCO do not have the "boots on the ground" care coordinator staff, while the CMHCs do.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

- The RCCOs should focus on non-medical systems only when these systems impact the health care of a Medicaid member. To take on the coordination of other systems would distract from the focus on healthcare that this RFI/RFP seeks to address.

Non-medical need:	Should the RCCO have a role?	Should the RCCOs coordinate with community supports and services?	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?

	Yes	No	Yes	
Abuse, neglect, and trauma	☐	☒	☒	Coordination occurs at the provider, not the RCCO. The RCCO needs to design supports and incentives for this to occur.
Affordability (assistance with prescriptions or co-pays)	☒	☐	☐	same
Daycare / childcare	☐	☒	☐	same
Economic stability & employment	☐	☒	☐	same
Education	☐	☒	☐	same
Environment	☐	☒	☐	same
Food access / nutrition	☐	☐	☒	same
Health literacy	☒	☐	☐	
Housing	☐	☒	☐	same
Language or translation services	☒	☐	☐	
Literacy	☐	☒	☐	same
Transportation	☒	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?

Advanced Practice (Registered) Nurses	☐	☒	
Certified Addiction Councilors	☐	☒	
Certified Nurse Midwives	☐	☒	
Community Health Workers	☒	☐	Primary responsibly deepening on organizational structure.
Generalists (BA/BS/MA/MS)	☒	☐	Primary responsibly deepening on organizational structure.
Health Coaches	☒	☐	Primary responsibly deepening on organizational structure.
Licensed Clinical Social Workers	☐	☒	
Licensed Marriage and Family Therapist	☐	☒	
Licensed Mental Health Counselors	☐	☒	
Licensed Professional Counselor	☐	☒	
Masters of Public Health	☐	☒	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☒	
Nurse Practitioners	☐	☒	
Patient Navigators	☒	☐	Primary responsibly deepening on organizational structure.
Peer Advocates	☒	☐	Primary responsibly deepening on organizational structure.
Promotoras	☒	☐	
Psychiatrists	☐	☒	
Psychologists	☐	☒	
Registered Nurses	☐	☒	
Social Workers	☒	☐	Primary responsibly deepening on organizational structure.
Wraparound facilitators	☒	☐	Primary responsibly deepening on organizational structure.
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe

Newborns and infants	☐	☒	
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☐	☒	I'm not sure how socially complex is defined.
Children involved in the foster care system	☒	☐	
Children with a chronic illness	☒	☐	
Children with a serious emotional disturbance	☒	☐	Care should be coordinated by the BHO and CMHC
Children with medical complexity	☐	☒	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	Care should be coordinated by the BHO and CMHC
Transition-age adolescents	☐	☒	
Parents and families	☐	☒	
Pregnant women	☐	☒	
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☐	☒	
Adults with a chronic illness	☒	☐	
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	Care should be coordinated by the BHO and CMHC
Clients involved in the criminal justice system	☐	☒	
Clients with a disability	☐	☒	
Clients in a nursing facility	☐	☒	
Elderly clients	☐	☒	
Frail elderly clients	☐	☒	
Clients in palliative care	☐	☒	
Other populations, please comment: DD			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

- The RCCO should only be involved if there are medical issues.

19) How should care coordination be evaluated? How should its outcomes be measured?

- Care coordination measures should monitor the reduction of duplicated care and the resulting reduction in medical expenses and the impact of this on health status.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

- This is very difficult to answer without actuarial analysis. The RCCOs may have a better handle on this. What is not advisable are rate cuts after the program has been implemented. This has occurred in the RCCO program as well as the BHO program. These changes can be very disruptive to the successful implantation of effective program strategies.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

- Same as above.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

- It should vary by population but needs to be set by an actuarial analysis.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☒
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

- Cost of care – reduction in wasted care because of un-coordinated care. And the impact of this on health outcomes.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- I would agree with the list provided above with the exception of provider contracts includes payment mythologies. Provider contracting creates a competitive edge that saves money for the state and should be left to the RCCO to manage.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

- There is a danger in being too prescriptive in the RFP by requiring RCCOs to have certain community relationships. It would be better to have RCCO bidders describe the relationships they have and how they will enhance those relationships. Points should be awarded in the RFP for community relationships.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

- I don't think this will work in rural and frontier areas of the state. These areas don't have the population needed to make this work.

27) Should the RCCO region maps change? Why or why not? If so, how?

- The state should go to fewer RCCOs and should consider combining RCCO regions 4 and 7. Most care in this part of the state is accessed through two major hubs, Pueblo and Colorado Springs. Having these regions in one RCCO will make care coordination much more effective.

28) Should the BHO region maps change? Why or why not? If so, how?

- If the BHO maps were changed a new BHO RFP would have to be issued. I don't think the BHO maps can be change unless the state is ready to combine both (RCCO and BHO) programs. To change the BHO maps without combing the programs would be very disruptive to the BHO patients.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

- At least 6 months minimum would be needed.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

- Moving to risk contracts would make the ACC more effective and produce saving more quickly. Allowing RCCOs to manage a PMPM for care I believe will show significant saving quickly. If quality

measures are added to the development of the PMPM, I believe that care and access can also be positively impacted.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

- The addition of 9900 and 9600 codes that allow integrated sights to provide services that are needed would be a major improvement.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

- I don't think this can work in rural /frontier Colorado, the population could not support two RCCOs. See question 26 above

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

- N/A

34) What role should RCCOs play in attributing clients to their respective PCMPs?

- Don't have the information to answer this question.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

- Both should eb concerned with prevention and population health

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

- none

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

- Medicaid is already a big enough task for the RCCOs; we should not put more on them.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

- DOI - only if there is a need for a license because of a risk contract.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

- There is a tendency to over burden programs with stakeholder processes and engagement that rarely produces any meaningful outcomes. Most of the time outreach meetings are poorly attended with input coming from many of the same stakeholders who often provide input directly.

  I would suggest that the RFP allow bidder to propose a meaningful stakeholder process that works for their area.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

- See answer to Question 39.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

- This can be accomplished through the RFP awarding points for community involvement.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

- See question 39 above.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

- No
  a. If no, what are the gaps?

- Access to specialty care in rural/frontier parts of Colorado is a problem.

  b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

- I don't think the gaps are population specific.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

   Hospitals are a key part to achieve true cost reform and must be a part of change

b. What role should pharmacies play in the next iteration of the ACC Program?

- I don't see a role for pharmacies.

c. What role should specialists play in the next iteration of the ACC Program?

- Specialty care needs to be more accessible in rural/frontier counties. The ACC program should provide incentives to specialists to provide care in these areas. The expansion of tele medicine should be strongly encouraged.

d. What role should home health play in the next iteration of the ACC Program?

- Home health should be a central part of care planning. Hospitals should be required to work closely with home health agencies.

e. What role should hospice care play in the next iteration of the ACC Program?

- Hospice care should be readily available to all patients in the ACC program.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

- Perhaps none initially, but then are added in and managed by the RCCO

g. What role should counties play in the next iteration of the ACC Program?

- This question is too broad.

h. What role should local public health agencies play in the next iteration of the ACC Program?

- Public health agencies need to be an integral part of the referral resource for the ACC program.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

- HCPF should be cautious of over reaching and involving too many player in the ACC process thus making it burdensome to carry out the main mission of the program, deliver better, more coordinated care to a larger number of Medicaid members.

45) How can RCCOs help to support clients and families in making and keeping appointments?

- This will always be challenging but extensive outreach is the only approach that has worked for the BHOs

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

- No, this should be an option proposed by the respondents to the RFP. HCPF should be careful not to be too prescriptive in how the RCCO program should operate. Leaving room for communities to offer solutions should be a key theme of the RPF.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement should be at the discretion of the RCCO and should not be prescribed by HCPF in the RFP.

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

- The RCCOs should have a role in coordinating oral health. Oral health need to be a part of overall health care and needs also be integrated.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

- Good customer service that understands local customs and traditions.

b. What RCCO requirements would ensure cultural competency?

- The fallacy in this question is that requirements can drive cultural competency. I've yet to see this work in any real world setting. Asking bidders to describe the uniqueness of their community and how they see themselves addressing their need will give HCPF an insight into the bidder's ability to ensure culturally competent services. These values need to be ingrained in the organization's culture; no amount to requirements will drive these values if they aren't already there. HCPF should select bidders who can demonstrate this competency.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

- The skills must be driven by the values of the organization.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

- See 49 b. above

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

- This should be at the discretion of the RCCO to address region specific issues and should not be prescribed by HCPF.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

- The RCCO bid should reward the respondents for proposing programs and services that divert patients from emergency rooms for routine care. The bid should redirecting these recourse to the RCCOs to develop additional programs and services that keep patients from accessing expensive emergency room care.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

- **The state should avoid designing a one size fits all program for the ACC. While many of these tools, programs and services are useful and can work, it should be up to the bidders to make a case to HCPF on how these fit the specific community they work in and what benefit they believe can be derived from their use.**

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☒	☐	☐
Network provider education	☐	☒	☐	☐
Assistance with practice redesign	☐	☒	☐	☐
Assistance with efficiency-enhancing activities	☐	☒	☐	☐
Provide web-based resources and directories	☐	☒	☐	☐
Provide practice-specific data reports	☐	☒	☐	☐
Provide clinical care guidelines and best practices.	☐	☒	☐	☐

Provide clinical screening tools	☐	☒	☐	☐
Provide health and functioning questionnaires	☐	☒	☐	☐
Provide chronic care templates	☐	☒	☐	☐
Provide registries	☐	☒	☐	☐
Offer client reminders	☐	☒	☐	☐
Offer client self-management tools	☐	☒	☐	☐
Offer educational materials about specific conditions	☐	☒	☐	☐
Supply behavioral health surveys	☐	☒	☐	☐
Supply other self-screening tools	☐	☒	☐	☐
Administer behavioral health surveys	☐	☒	☐	☐
Administer other self-screening tools	☐	☒	☐	☐
Prepare client action plans	☐	☒	☐	☐
Provide training on providing culturally-competent care	☐	☒	☐	☐
Provide training to supporting staff	☐	☒	☐	☐
Provide training on motivational interviewing	☐	☒	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☒	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☒	☐	☐
Provide referral and transitions of care checklists	☐	☒	☐	☐
Provide visit agendas or templates	☐	☒	☐	☐
Provide standing pharmacy order templates	☐	☒	☐	☐
Provide comprehensive directory of community resources	☐	☒	☐	☐
Provide directory of other resources	☐	☒	☐	☐
Provide materials regarding Nurse Advice Line	☐	☒	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☒	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

- N/A

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

- Rather than have requirements, have the bidders propose methods that would address this question.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

- Rate enhancements for participation in the RCCO program as defined by the RCCO in the bid response.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

- No

58) Please share any other advice or suggestions about provider support in the ACC.

- This section is very heavy on requirements. If these requirements are implemented as RFP requirements it leaves little or no room for creativity. It also shifts the success or failure from the bidder to the State. Winning bidder need only to focus on meeting the requirements to be successful rather than focus on solutions that meet the overall goal of population health.

  It would be better if the State allows bidder to offer solutions to improve population health and then monitor progress.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The RCCOs need to move to risk contracts that provide a PMPM that can be managed against goals for improved population health at a lower cost.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

- We are not primary care providers but our BHO has operated for 18 years by having providers take risk. Each of our Mental Health Centers operates on a Global Budget. We think this system of financing providers can work for primary as well.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

- No they are not. The biggest barrier is the fee for service system of reimbursement. The medical system in place currently is set up to generate volume not value, a fact that is known to anyone who has worked to reform the health care system. The biggest barrier is that there are no incentives for providers to move to a system that is based on value. In fact providers are penalized if they focus on value. The infrastructure will not be developed until the incentives for producing value are aligned with the payment structure. This transformation can best be achieved by introducing risk contract to the RCCOs that reward value rather than volume. I hope this can be done in the next RCCO bid.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

- Our organization is licensed by the DOI and we are ready and able to acquire any needed license and the required reserves. A license would not preclude us from bidding.

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

- RCCOs should be completely responsible for reimbursing providers they are required to manage.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Capitation payments (PMPM) with rate setting factors that reward quality

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

- The State should have broad measures of success for all RCCOs and should allow RCCOs to suggest additional measure that address local needs.

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	All of these should be options for measuring quality.
SF-12 Health Survey	☒	☐	
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☒	☐	
Focus groups	☒	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

- This needs to be the responsibility of the RCCOs but must be funded by the State.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

- Open and transparent though a website.

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7 at most	☒
8-10	☐
11-20	☐

21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☒
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

- It should be a combination. Overall KPIs should address population health but allow for local indictors to address community needs.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

- Based on improvements

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

- The Department should not be constrained by the claims dilemma. RCCOs can develop the systems to monitor progress. These systems can be audited for accuracy to assure the State of their validity. To wait until the State can develop a system would waste valuable time.

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

N/A

75) For potential Offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

- I don't know the fixed costs of operating a RCCO but I do know the fixed costs of operating a BHO which might have some similarities. The BHOs are required to have access standards for routine, emergent and emergency care along with access to providers within acceptable driving distances. In order to meet these standards we have to over staff. This is one example but there are many such requirements in our current contract that drive cost. RCCO RFP requirements will drive fixed costs. That state should evaluate very carefully the whether these requirements will generate value to the health care system.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

- The BHOs are evaluated on 28 measures but reimbursement is not tied to any of them. We believe that these quality measures should be incorporated into the rate setting process for the BHOs. A similar process could be used to set RCCO rates if the state chooses, and we suggest they do, move to risk contracts.

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☒
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☐	☒
Smartphone app	☐	☒
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☒
Digital care management tool	☐	☒
Care transitions alerts	☐	☒
Electronic Health Records (EHRs)	☐	☒
Health risk assessment software	☐	☒
Practice assessment tools	☐	☒
Practice management tools (scheduling, billing)	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☒
Patient education/wellness tools	☐	☒
Provider/case manager directory	☐	☒
Shared decision-making tools	☐	☐
Telemedicine software	☐	☒
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☒	☐
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☒	☐
Practice assessment tools	☐	☒	☐	☐	☐
Health risk assessment software	☐	☐	☒	☐	☐
Practice management tools (scheduling, billing)	☐	☒	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☒	☐	☐	☐

Patient education wellness tools	☐	☐	☒	☐	☐
Provider/case manager directory	☐	☐	☐	☒	☐
Shared decision-making tools	☐	☐	☒	☐	☐
Telemedicine	☐	☐	☐	☐	☒
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

- Staff feeling comfortable with the technology and rules for reimbursement is the primary barrier.

81) How can Health Information Technology support Behavioral Health Integration?

- Information technology will benefit all of health care with behavioral health being equally impacted. The ability to reach out to rural/frontier areas will be of special interest to the rural BHOs and RCCOs. CHP has invested heavily in tele-medicine for this reason.

  One challenge we are facing is the integration of medical information. There currently does not exist an electronic medical record (EMR) that can handle both primary care and behavioral health. This is a very big barrier to true integration. We are meeting this challenge through creative bridging of two EMRs but this is not an ideal solution. The expense of having to buy two systems may deter many providers from embracing the true impact that interstation can achieve. We are happy to share our experience.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

- Yes there should be a shared system for data and analytics. However, the state has been challenged to implement even a basic system of data sharing. I believe better results would be achieved if this task was given to the RCCOs and BHOs. The RPF should require that the contracting entities transmit analytics to the state rather than have the state develop a state wide system for data and analytics.

  The RFP could require that RCCOs track cost of care; health outcomes and other health outcome measure and be able to transmit these data in a common platform.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

- And effective care management tool must monitor access to care on a real time basis. Care managers need to know when appointments are made, prescriptions are filled and emergency rooms are accessed. Currently most care management is addressed after the fact and can only prevent future problems rather than intervene as duplicate and inappropriate care is being planned.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

- This task should be the responsibility of the RCCO. The tool could look at the overall use of care by a population and identify duplicate and inappropriate care so that these trends can be addressed with the providers in the network. This arrangement works best under a risk model where providers are incentivized to be efficient.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

- The Connect for Health Colorado provider resource guide is a good model for such a directory. Members and care managers should be able to search for providers based on the needs of the patient.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

- The solution is clearly an effective CORHIO and QHN. Anything short of this would not be as effective.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

- A combined primary care – behavioral health EMR, the effective implementation of CORHIO/QHN with access for primary care providers and a real time system that tracks access to care.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

- The RCCOs in rural/frontier areas should be the primary source of HIT infrastructure. Most provider groups with the exception of hospitals and FQHCs cannot afford nor can they support the HIT systems needed. The RFP should accommodate this condition.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

- See question 86 above.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 049

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

Realize Your Care Continuum

GSI Health

RESPONSE TO
ACCOUNTABLE CARE COLLABORATIVE
REQUEST FOR INFORMATION

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Contact Information:

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Core ID # RFI UHAA 2015000017
Response Date: November 23, 2014

Cover Letter

June 8, 2015

TO: Kevin Dunlevy-Wilson
Department of Health Care Policy and Financing
Accountable Care Collaborative Strategy Unit
1570 Grant Street
Denver, CO 80203-1818

RE: RFI Response

Dear Mr. Dunlevy-Wilson,

GSI Health, LLC is pleased to submit our comments and response to portions of the Request for Information RFI UHAA 201S000017 Accountable Care Collaborative Request for Information.

Our solution has been in commercial use since 2011 with over 940 affiliated provider organizations and a Fortune 50 Managed Care Organization currently leveraging GSI Health's solution nationally to coordinate care. We have drawn upon our experience and those of our customers in assembling our comments included in this document.

Thank you for your time and consideration in reviewing our response. Please contact me directly with any questions you may have about GSI Health or our response.

Sincerely,

Lori Evans Bernstein
President
GSI Health, LLC
7 Times Square
New York, NY 10036

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GSI Health Introduction

GSI Health was founded in 2003 and originally provided consulting and software solutions for clients focusing on cutting-edge health IT initiatives. Since 2010 GSI Health has been developing GSIHealthCoordinator, our SaaS based care coordination and population health management solution for Medicaid and special need populations such as the Dual Eligibles. GSIHealthCoordinator has been specifically designed to support Medicaid integrated health care delivery programs.

Our solution has been in commercial use since 2011 with over 940 affiliated provider organizations and a Fortune 50 Managed Care Organization are currently leveraging GSI Health's solution nationally to coordinate care. Patient volume within the solution has increased 12-fold in the last year.

Within one of our Medicaid Health Home customers, program enrollees of at least one year have seen a consistent decline in inpatient admissions, from 10.1 admissions per 100 patients in August 2013 to 4.1 in January 2014 – a reduction of more than 50%.

GSI Health's executive team possess deep domain expertise and are nationally recognized leaders in care management, care coordination, and health information exchange. Over the last 20 years, the executive team has served various roles in shaping the emerging healthcare standards including, but not limited to:

- Senior Advisors to the former ONC for Health IT Chair, Dr. Brailer
- Chair of the National Health Information Technology Standards Panel
- Deputy Commissioner of the New York State Department of Health IT
- Chair of the National Consolidated Informatics Initiative

This experience combined with an innovative solution platform has enabled GSI Health to enable various healthcare initiatives nationwide (i.e., Medicaid Health Homes, Medicaid ACOs, Duals Programs, etc.) to proactively manage and coordinate the care of 150,000+ patients reducing emergency room utilization while preventing avoidable hospital admissions and readmissions.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Lori Evans Bernstein
Location: New York, New York

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Not Applicable
Location: Not Applicable
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Software Vendor

Are you currently involved in the ACC program?

☐ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

How have you been involved in the ACC program and what interaction have you had with RCCOs:

GSI Health is not involved in the ACC program but our solution is being leveraged by 940 affiliated provider organizations and a Fortune 50 Managed Care Organization to coordinate the care of over 150,000 patients.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

GSI Health is the prominent solution being used in the State of NY Health Home initiative and is currently working with many of the Health Homes on their upcoming DSRIP initiative. We also have presence in the States of WA, NM, MO, TX, AZ, TN and OH.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☒ N/A

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

2) What is not working well in the ACC Program?

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

To effectively integrate behavioral health, it is important that a coordinated care plan (CCP) exist for the patient that includes the clinical, behavioral, and social areas of care. The CCP should then be available in real-time by the care team where they can access the patient issue, goals, treatment, and interventions/progress against those issues to monitor outcomes. It is our experience that a patient's care team minimally includes care management, behavioral health and primary care providers from multiple stakeholder organizations.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

The efficient tracking, referral, coordination and analysis of patient care across the full continuum, including ambulatory, acute, post-acute, long term and home care facilities and programs. For example; a diverse interdisciplinary care team creates and manages a shared coordinated care plan between medical, behavioral and social service providers and track real-time patient adverse event notifications and changes in medications and diagnoses.

b. How should RCCOs prioritize who receives care coordination first?

Depending on the State and program (i.e., Medicaid Health Home, Duals, etc.), many of our customers are provided the list of patients. They have relied on population size to determine the prioritization approach. Small populations are approached as a whole while applying methodologies for population segmentation, risk stratification and predictive risk are used to prioritize care within large populations.

The parameters in which to analyze and identify priority patients varies by state and program and will depend on Colorado's goals.

c. How should RCCOs identify clients and families who need care coordination?

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

GSI Health recommends a shared coordinated care plan between medical, behavioral and social service providers jointly track conditions, manage and assign care steps and track real-time patient adverse event notifications and changes in medications and diagnoses. Typically the care is coordinated by a designated care manager / navigator.

12) What services should be coordinated and are there services that should not be a part of care coordination?

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	

Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	
Health literacy	☐	☐	☐	
Housing	☐	☐	☐	
Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	
Transportation	☐	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved. The list of services coordinated by the RCCO will be largely dependent upon the needs of the patient population. An emphasis should be placed on "whole" person care that crosses the medical, behavioral, and social aspects of care. Within one of our Medicaid Health Home customers that adopted this approach, program enrollees of at least one year have seen a consistent decline in inpatient admissions, from 10.1 admissions per 100 patients in August 2013 to 4.1 in January 2014 – a reduction of more than 50%.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	**Coordinate care?** Yes	No	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	

Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Please type your response here. Additional roles will be dictated by the patient population. For example; several of our Health Home customers in New York include a Probation Officer on their care team for patients that have a history of incarceration.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment: For those patients that have a history of repeated incarceration, you will need to decide if the care coordination extends into the correctional facility or is suspended until released.			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

Measurement will be determined by the goals of your initiative (i.e., reduce readmissions, HbA1C < 7, etc.). Within one of our Medicaid Health Home customers, program enrollees of at least one year have seen a consistent decline in inpatient admissions, from 10.1 admissions per 100 patients in August 2013 to 4.1 in January 2014 – a reduction of more than 50%.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

Software solutions to support the care coordination services are typically based on a PMPM based fee and vary on functionality provided. Fees can range from $1.50 PMPM on down depending on extended functionality and population size.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

We have seen the PMPM vary by level of services/care. For example, in WV has separated the types of services provided into two tiers. Tier 1 provided services are reimbursed $51 PMPM while Tier 2 services are reimbursed $229.50 PMPM (Source: State of WV Medicaid website).

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐

3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

GSI Health recommends a common solution supporting a coordinated care plan that spans medical, behavioral and social service areas of care. The solution should enable providers to jointly track conditions, manage and assign care steps and track real-time patient adverse event notifications and changes in medications and diagnoses.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

GSI Health's customers chose to limit scope and phased in the required capabilities. For example, many of our Health Home customers started only with the coordinated care plan that enabled the program start within 60 days (Phase I). During this time they identified appropriate external data sources for both claims and clinical information and brought them online (Phase II). Also completed during this time were required state reporting, etc.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

A growing trend within population health management is engaging and including the patient. One way of doing this is to require the patient or patient advocate be a member of the care team. As a first step (and a member of the care team), patients and/or patient advocates should be provided the means of securely communicating with other members of the care team via the Direct protocol.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47) **Community Health Worker reimbursement**. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care	☐

Medical Provider Clinic	
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

The ability to track and provide real-time patient adverse event notifications and changes in medications and diagnoses is critical here. A notification to the care manager that one of their assigned patients is in the emergency room provides the opportunity to intervene, address the care needs appropriately, and prevent a readmission.

The coordinated care plan is also critical. As experienced within one of our Medicaid Health Home customers, program enrollees of at least one year have seen a consistent decline in inpatient admissions, from 10.1 admissions per 100 patients in August 2013 to 4.1 in January 2014 – a reduction of more than 50%.

The coordination of care when applied consistently works.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐

Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐	
Others	GSI Health recommends that the agreed upon processes and procedures be centrally located to ensure efficiency for updating and across all RCCO participants. Also ensure that the care coordination solution being used across the RCCO contains a library of assessments that will automatically score the results and update the coordinated care plan with the identified issues and corresponding interventions / care plan steps. This will ensure protocol consistency across the RCCOs.				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

It is our experience that disease registries not be the sole path for managing the participating patient population as this narrows the focus to just clinical indicators. Rather, it should be a combination of clinical, social, and behavioral factors for managing the population. For example; a diabetes patient may not understand how to monitor their blood sugar or not able to provide themselves with the proper nutrition. Knowing these additional factors will help the PCMP to assign care plan tasks to the appropriate care team members resulting in approaching whole person care resulting in more positive, higher quality outcomes.

58) Please share any other advice or suggestions about provider support in the ACC.

In addition to the coordinated care plan shared by all members of the care team, additional patient information via a longitudinal patient record assembled from community data sources can provide value. Especially if the information most appropriate to the current patient care can be pulled forward by the care team into a patient summary. For example; only the current most impactful meds with confirmation that the scripts were filled could be front and center instead of searching through a long listing of prescriptions.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years

Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the 5DAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Indicated below are the tools that we see most used by our Medicaid Health Home Clients.

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☒
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐

Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☒
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☒
Shared decision-making tools	☐	☐	☐	☐	☒
Telemedicine	☐	☐	☐	☐	☐
Other: Predictive Analytics / Risk Assessment	☐	☐	☐	☐	☒

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

81) How can Health Information Technology support Behavioral Health Integration?

To effectively integrate and support behavioral health, it is important that a coordinated care plan (CCP) exist for the patient that includes the clinical, behavioral, and social areas of care. The CCP should then be available in real-time by the care team where they can access the patient issue, goals, treatment, and interventions/progress against those issues to monitor outcomes. It is our experience that a patient's care team minimally includes care management, behavioral health and primary care providers from multiple stakeholder organizations.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

It is important that a coordinated care plan (CCP) exist for the patient that includes the clinical, behavioral, and social areas of care. The CCP should then be available in real-time by the care team where they can access the patient issue, goals, treatment, and interventions/progress against those issues to monitor outcomes. It is our experience that a patient's care team minimally includes care management, behavioral health and primary care providers from multiple stakeholder organizations. Additionally the solution should contain a library of assessments that auto score and update the CCP with the diagnosed issue list and associated interventions and care plan steps.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

A shared population health management tool can be paired with the CCP for optimal effectiveness. Typically, the tool would be used by the organization responsible for managing the care of the patient population. The tools This initiative will need to determine how much of the capabilities would be extended to the care team.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

Via a coordinated care plan (CCP) that includes the clinical, behavioral, and social areas of care. The CCP should then be available in real-time by the care team where they can access the patient issue, goals, treatment, and interventions/progress against those issues to monitor outcomes. Additionally, the CCP should have the ability to generate alerts to the care team for various events including, but not limited to, emergency room visits, admission / discharge, change in care plan, etc.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

The majority of our customers leverage the state and regional HIEs and data sources to minimize the number of required interfaces. For example; if 15 hospitals are already sending information to QHN, only a single interface to QHN would be needed to incorporate and take advantage that information vs an interface to each hospital, etc.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Appendix: GSI Health Solution Overview

GSIHealth*Coordinotor* is a highly scalable and extensible web based solution offered via a Software-as-a-Service model. The solution is based on the HIT standards for healthcare interoperability and security with user interaction occurring through a web browser.

The data flow and system interaction is facilitated by an embedded full-service, Master Patient Index (MPI) and standards based Health Information Exchange (HIE). The HIE is based on Integrating the Healthcare Enterprise (IHE) recommended standards and supports transactions for managing patient identity and exchanging clinical information. These services are leveraged to achieve interoperability amongst GSIHealth*Coordinotor* apps and to integrate with external systems (i.e., HIEs, RHIOs, EMRs, etc.) systems to exchange health home patient information. Using the standards-based backbone for interoperability helps our platform efficiently integrate with disparate systems to get data required for care coordination.

The GSIHealth*Coordinotor* solution platform is comprised of the following layers:

- **Care Coordination Applications** - an extensible application layer providing the necessary set of applications (i.e., messaging via Direct protocol, alerts, patient summary, virtual care plan, patient engagement, etc.) to enable care coordination. A grouping of applications can be configured to meet initial needs and then extended as initiative requirements evolve.

- **Reporting and Analytics Applications** – a set of applications that include predictive analytics, predefined reports, and ad-hoc reporting capabilities to meet the patient identification, reporting, billing and score carding needs of your initiative.

- **Clinical Data Repository** – a robust data layer containing both claims and clinical data including the flexibility to add additional conditions and measure sets as needed for population health management initiatives. Fully HIPAA compliant, the solution maintains the appropriate audit trails.

- **Data Interoperability** – this layer enables our solution to exchange both claims and clinical data to and from a variety of systems (i.e., HIE, EMR, Payer, Lab, etc.) while leveraging the investment of our customers' current systems. Exchanged information includes patient demographics, clinical data, HL7 and ADT, consent, alerts, care plan, and secure messages.

GSI Health employs a phased implementation approach. This approach allows GSI Health to best meet the needs of each customer's program and allow for incremental workflow adjustments as the program model is implemented. First operational use of the solution is typically within 90 days.

GSIHealthCoordinator Apps

Enrollment App - The Enrollment App facilitates patient enrollment into integrated care programs such as Health Home, and others, and manages the necessary patient consent policies. Patients can be added to the application via batch process, real-time interface, or directly into the App manually. Care managers can immediately start enrolling patients in the Health Home or other integrated care program(s), manage consent and document outreach activities. Patient consent is managed dynamically at the organizational level and individual provider level.

Care Teams App – The Care Teams App enables the creation of interdisciplinary care teams within and among various providers, care management and social service organizations and the assignment of patients to them. Care teams can be created in advance or in real-time and modified as needed. A patient's care team can include up to 10 roles, including supervisor, specialist, staff extender, care management, primary care, and behavioral health and social service providers. The care team has access to patient information, the coordinated care plan and receives alerts regarding patient care services, adverse events and care plan updates.

Care Plan App – The Care Plan App is a specialized, dynamic clinical assessment and care planning tool. It enables integrated, whole person care providing a patient-centric view of all medical, behavioral and social services issues, goals and interventions accessible in real time to all members of the care team through a Coordinated Care Plan (CCP). The Care Plan App has as a robust library of over 100 assessments to choose from and the ability to configure customized assessments. All assessments include integrated scoring, interpretation, trending and auto-populate issues and care steps in the CCP. Monitoring progress against the care plan is supported by key features, including an audit log highlighting updates and changes to the care plan, filtering by particular domains such as housing, employment, substance abuse, notifications regarding updates or changes and patient input.

Messages App – The Messages App enables all members of the care coordination program to communicate securely with one another about patients via Direct. The Messages App supports the ability to securely attach documents to messages such as CCPs, patient summaries and/or CCDs, to facilitate transitions in care as the patient moves throughout the care delivery system. GSIHealthCoordinator's Messages App can also be configured with custom templates to facilitate referral management and a wide array of standard communications across the care team.

Alerts App – The Alerts App enables care team members to be automatically alerted to adverse events, including ED and inpatient hospital admissions/discharges and other care coordination events such as medication changes and updates to CCP such as a new intervention. The alerts are configurable based on user preferences and rendered within the alerting app which provides a short description of the alert event. A mobile application will be available to notify users of preferred alerts in the future. The Alerts App can connect to an HIE to receive data for a variety of event alerts.

Population Manager App – The Population Manager App is comprised of data analytics and business intelligence tools providing outcomes and operational measurement and reporting. A gap in care feature also allows for drilling down to the patient level for any measure. This enables users to create cohorts and registries based on clinical conditions and risk profiles to inform population management programs.

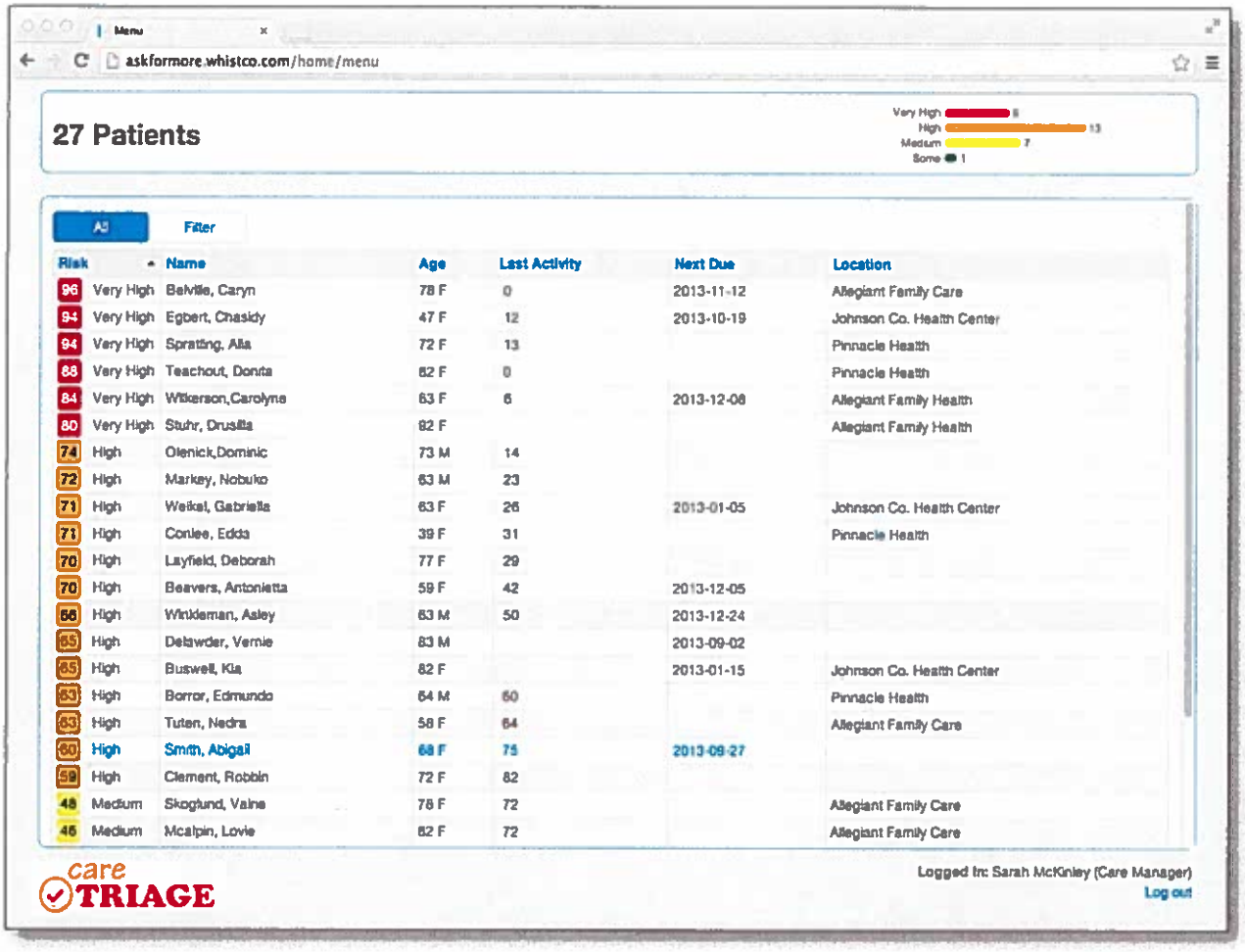
The Population Manager app includes an integrated data warehouse containing all data entered into GSIHealth*Coordinator* and from integrated HIEs, hospital administrative data and claims systems. Available is a library of Population Management Outcomes and Operational Measures and Reports for regulatory and non-regulatory reporting. Also available is the configuration of custom measure sets based specific customer requirements.

Carebook Patient Summary – The Carebook App provides longitudinal and care coordination-specific patient summaries with integrated Clinical Decision Support (CDS). With the Carebook app, care team members can review aggregated patient CCD data and select and authorize the import of specific current patient information such as medications, allergies, encounters and crisis information to create a patient summary specifically for care coordination purposes. The integrated CDS provides care team members with prompts when a patient's care summary deviates from predefined clinical protocols and evidence-based guidelines. The integrated CDS is getting piloted in the second half of 2014 and will be generally available in 2015.

Patient Engagement App – The Patient Engagement app enables patients to become members of their care team and communicate with their care team and for the care team to communicate with their patients through a secure messages feature. Providers can recommend relevant readings, disease management programs, and self-management programs to a patient as well as share clinical summaries and information with patients. Patients can view their care plan and medications and if available diagnostic test results and discharge summary. This application is currently being piloted and will be fully rolled out in 2015.

Caretriage Risk Stratification App – GSI Health has partnered with CCNC Services to incorporate its patent pending predictive modeling and risk stratification technology into GSIHealthCoordinator. Today Caretriage is driving an 800 care manager work force in North Carolina to target those patients that are most likely to be re-admitted and recommend the appropriate best practice pathways in order to provide better outcomes and lower cost. Caretriage brings time tested algorithms in order to predict risk and recommend the appropriate clinical pathways using integrated data sources such as pharmacy, claims and clinical data from GSIHealthCoordinator. This application is currently being integrated with GSIHealthCoordinator and will be fully rolled out in 2015.

A sample screenshot of the predictive modeling patient stratification is below.


Menu
askformore.whistco.com/home/menu
27 Patients
Very High 8
High 13
Medium 7
Some 1
All
Filter
Risk
Name
Age
Last Activity
Next Due
Location
96 Very High Belville, Caryn 78 F 0 2013-11-12 Allegiant Family Care
94 Very High Egbert, Chasidy 47 F 12 2013-10-19 Johnson Co. Health Center
94 Very High Spratling, Alla 72 F 13 Pinnacle Health
88 Very High Teachout, Donita 82 F 0 Pinnacle Health
84 Very High Wilkerson,Carolyns 63 F 6 2013-12-08 Allegiant Family Health
80 Very High Stuhr, Drusilla 82 F Allegiant Family Health
74 High Olenick,Dominic 73 M 14
72 High Markey, Nobuko 63 M 23
71 High Weikel, Gabriella 63 F 26 2013-01-05 Johnson Co. Health Center
71 High Conlee, Edda 39 F 31 Pinnacle Health
70 High Layfield, Deborah 77 F 29
70 High Beavers, Antonietta 59 F 42 2013-12-05
66 High Winkleman, Asley 63 M 50 2013-12-24
65 High Delawder, Vernie 83 M 2013-09-02
65 High Buswell, Kia 82 F 2013-01-15 Johnson Co. Health Center
63 High Borror, Edmundo 64 M 60 Pinnacle Health
63 High Tuten, Nedra 58 F 64 Allegiant Family Care
60 High Smith, Abigail 68 F 75 2013-09-27
59 High Clement, Robbin 72 F 82
48 Medium Skoglund, Vaine 78 F 72 Allegiant Family Care
46 Medium Mcalpin, Lovie 82 F 72 Allegiant Family Care
care TRIAGE
Logged In: Sarah McKinley (Care Manager)
Log out

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 050

Accepted by: KJDW

Notes: Redacted by order of HCPF Legal.

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

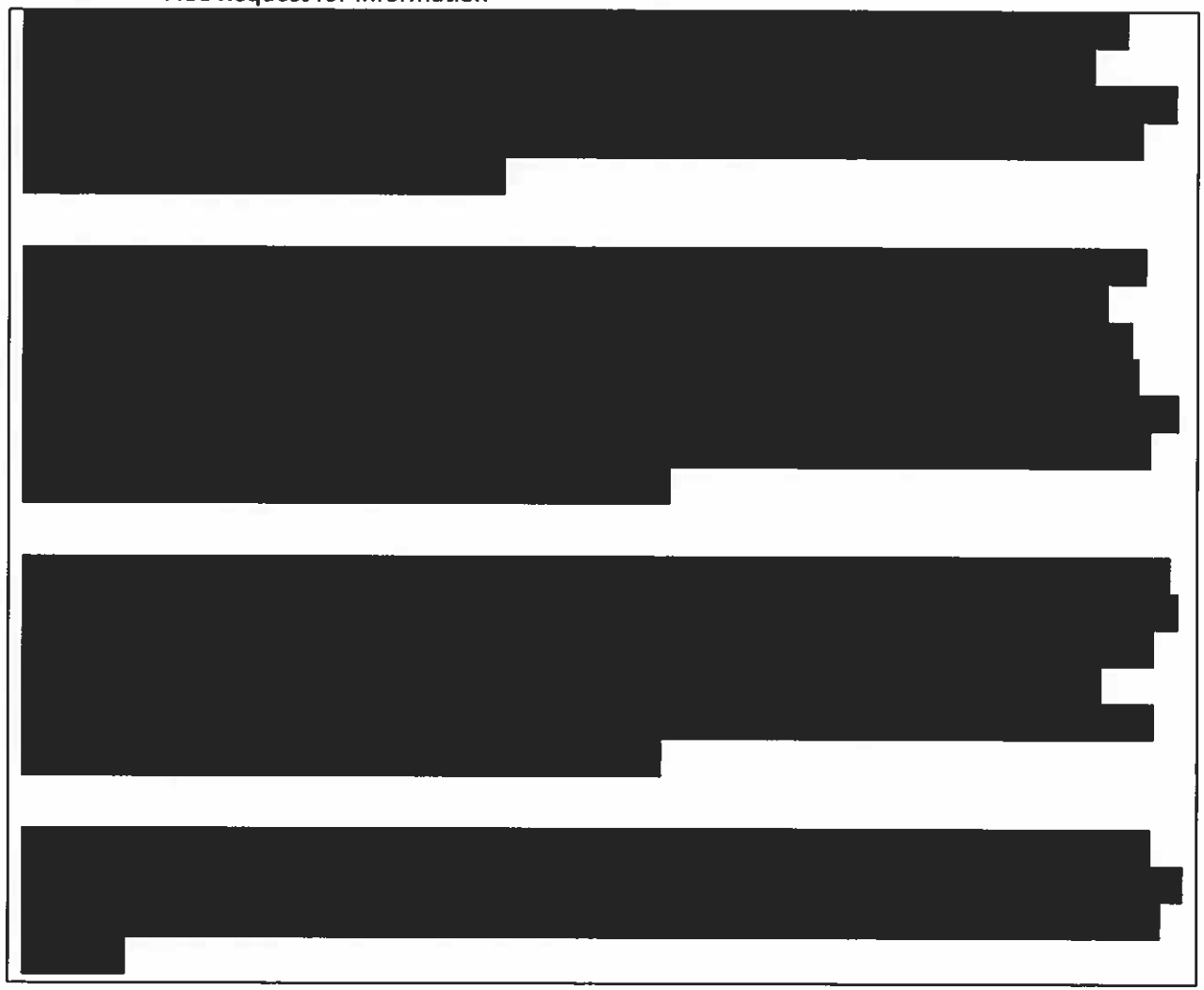
[redacted]

[redacted]

[1] Many terms and definitions can be found in the Appendix at the end of this document.

[redacted]

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.



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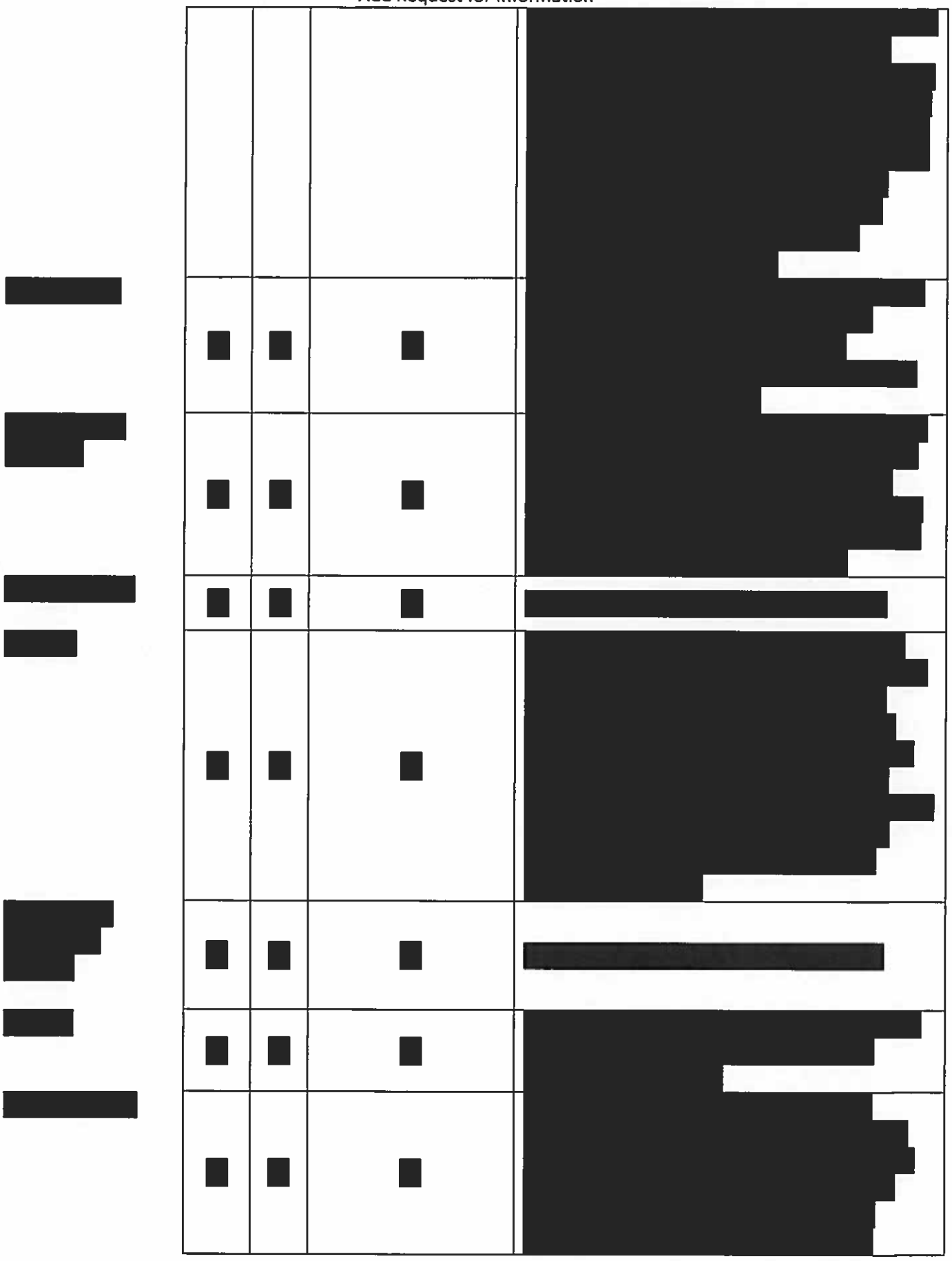

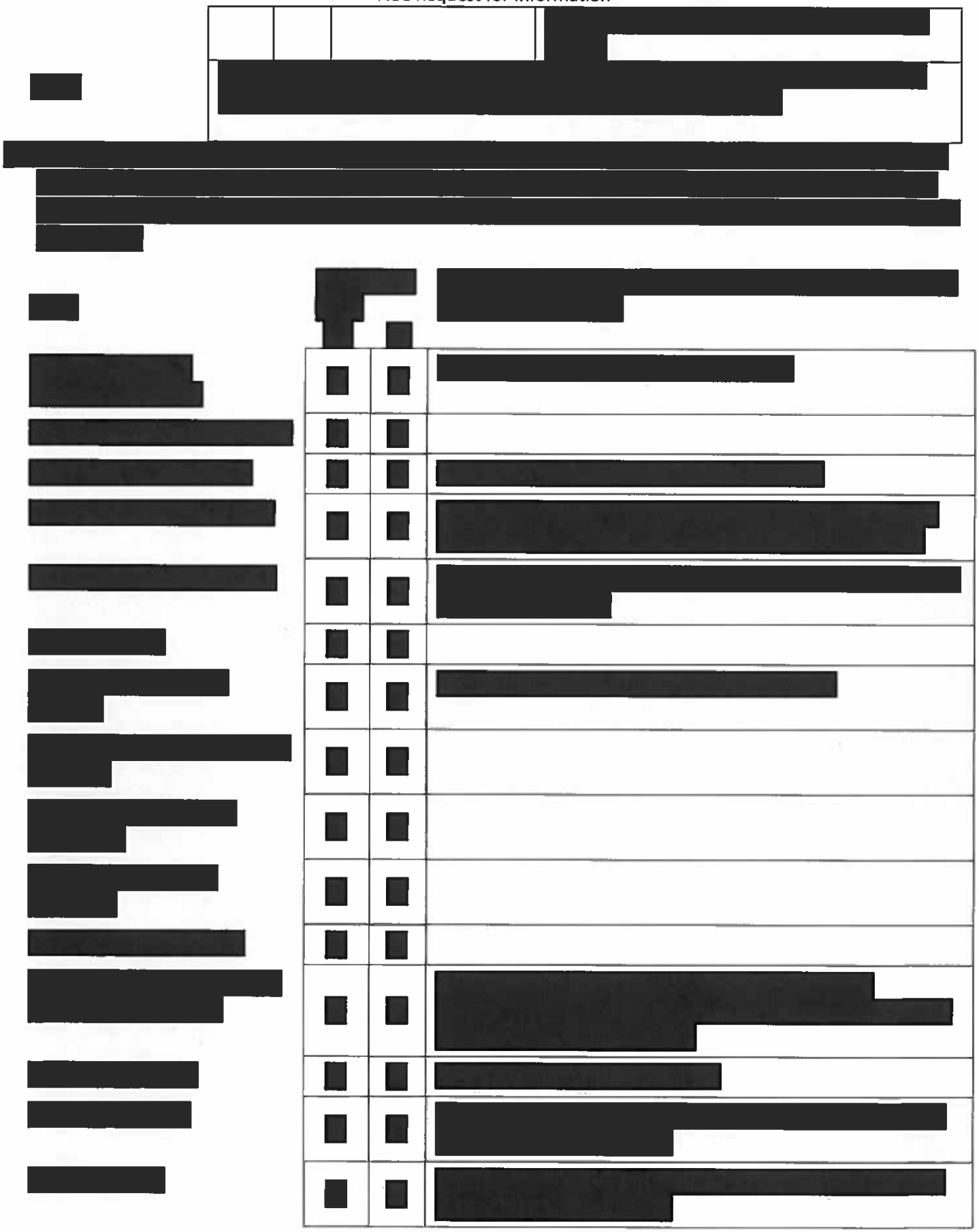

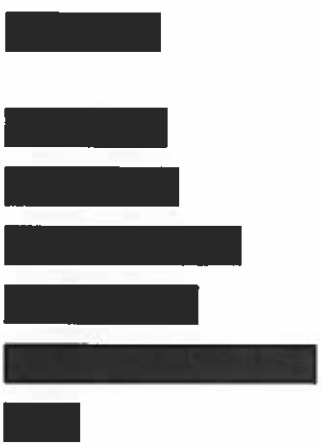

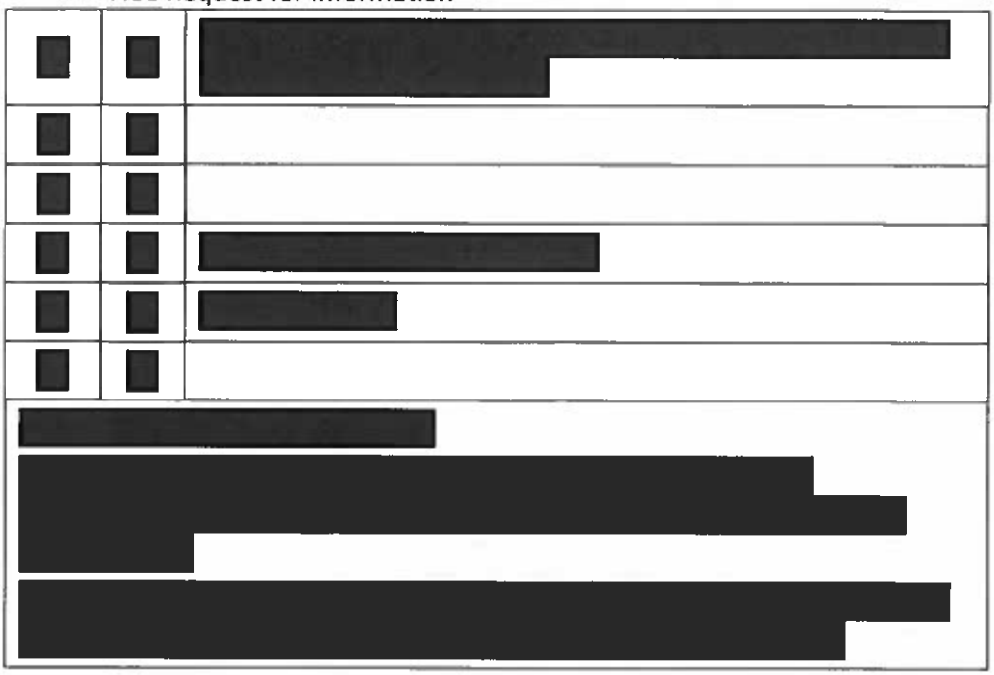

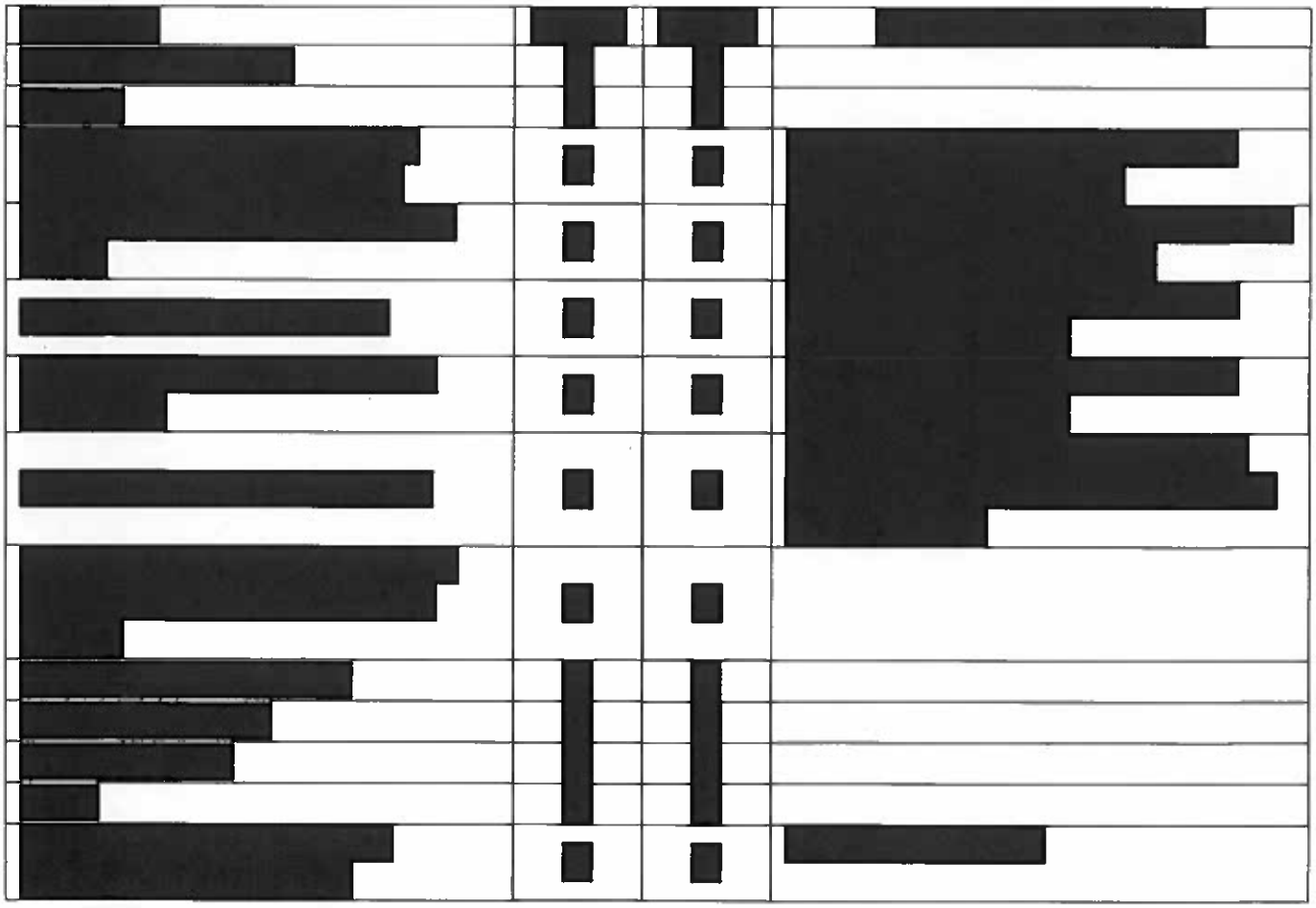

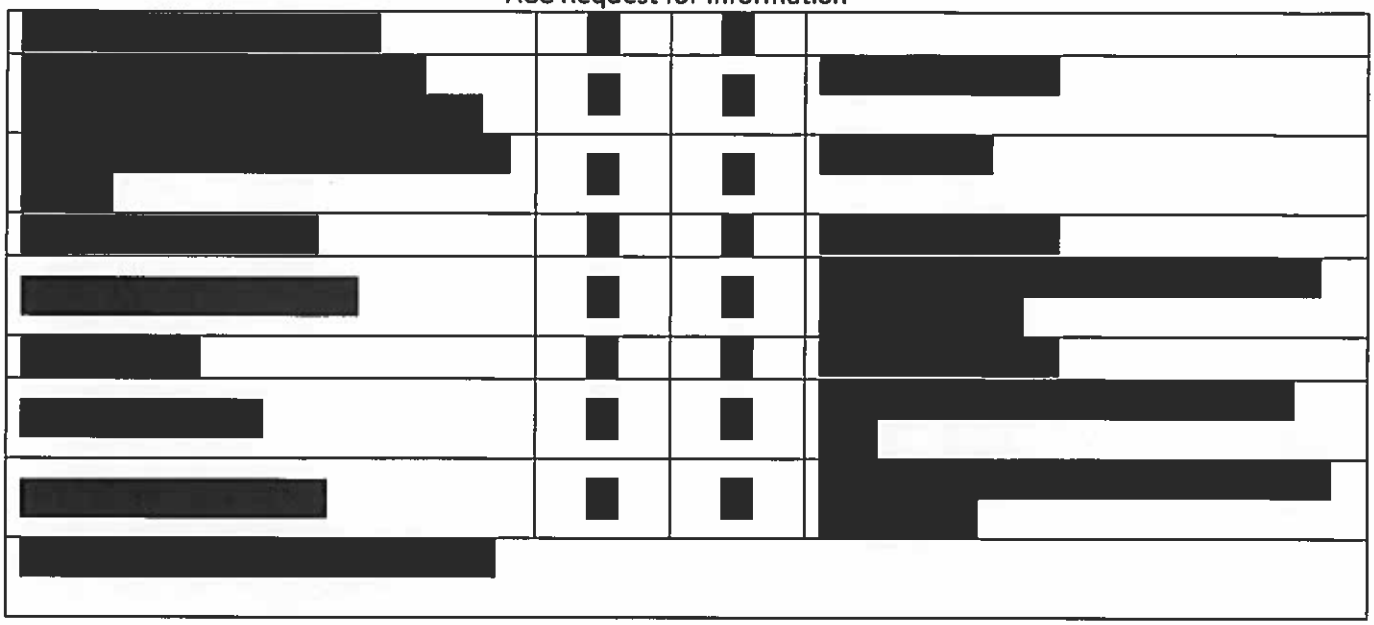

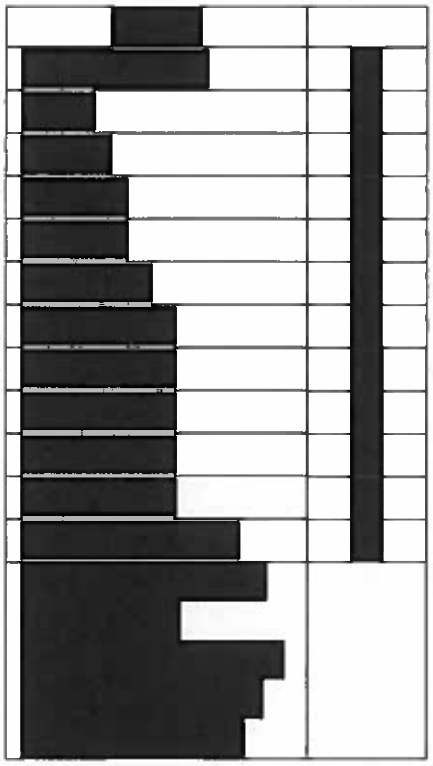

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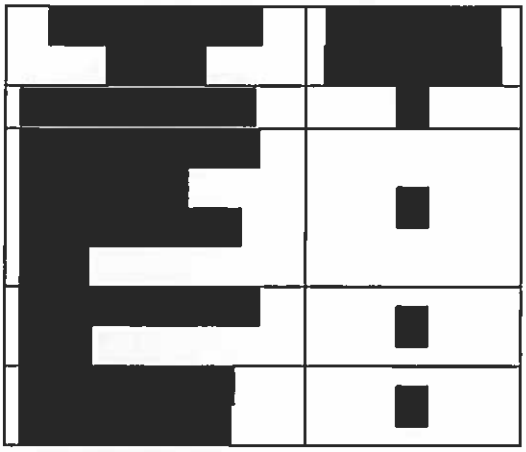

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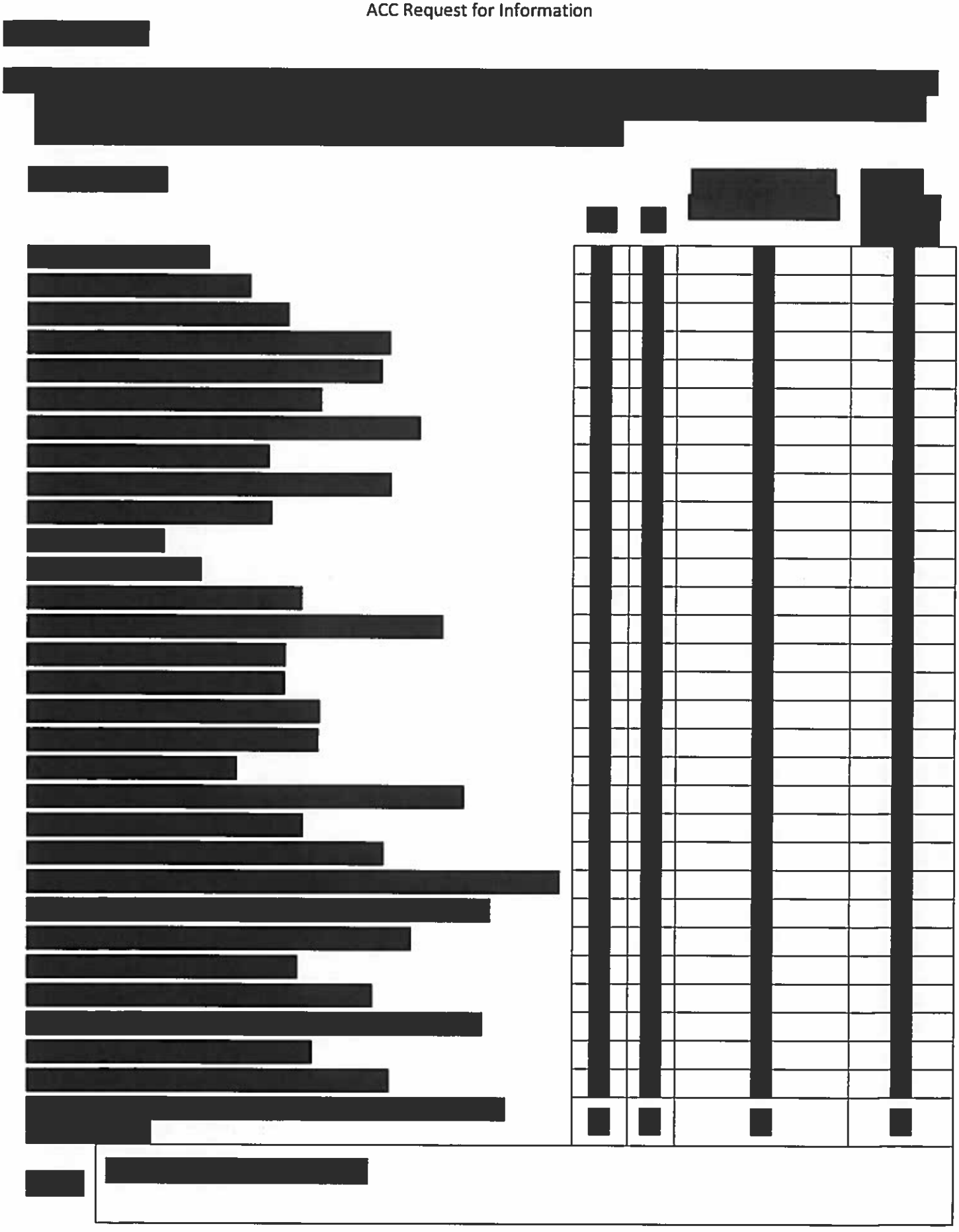

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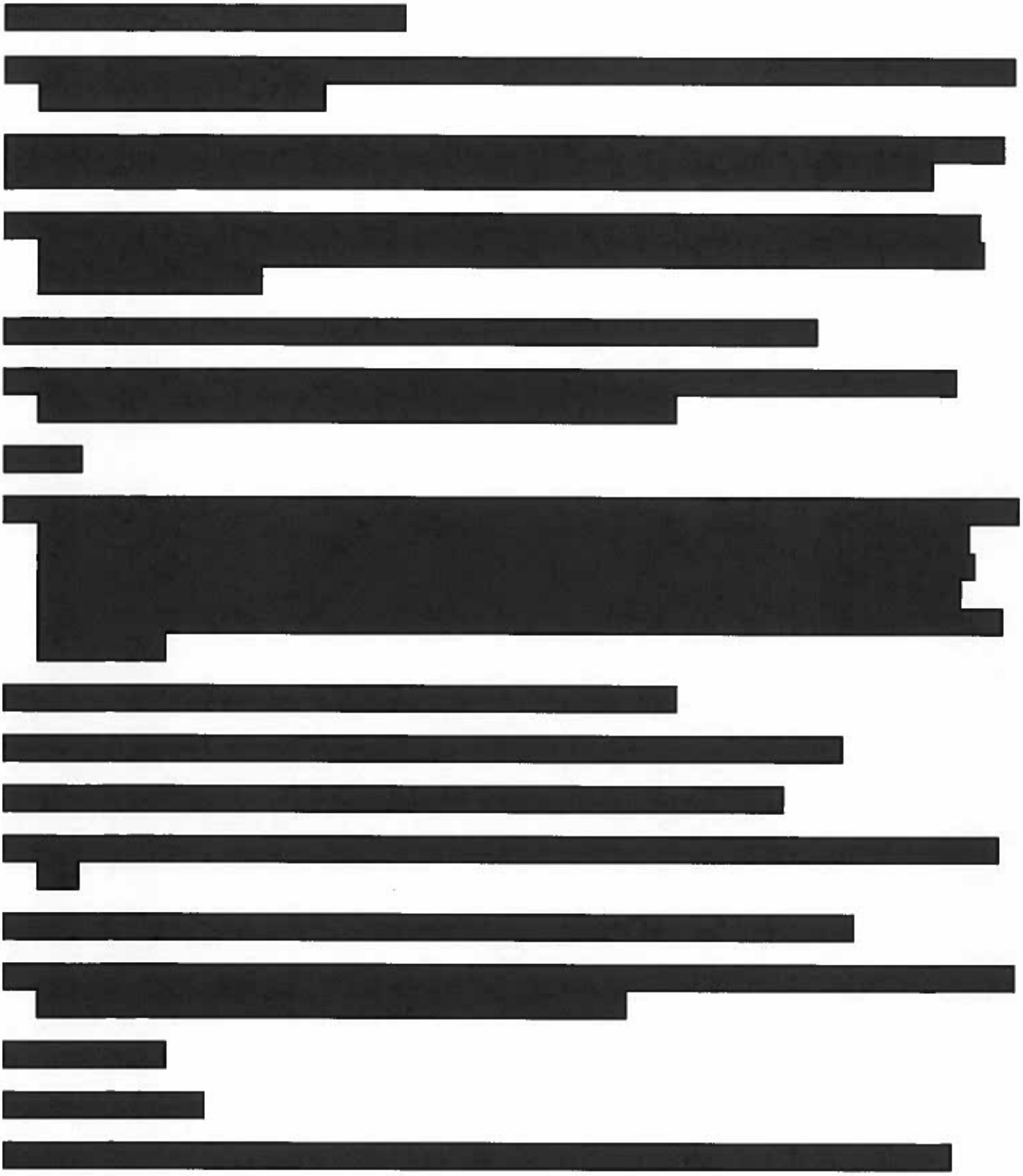

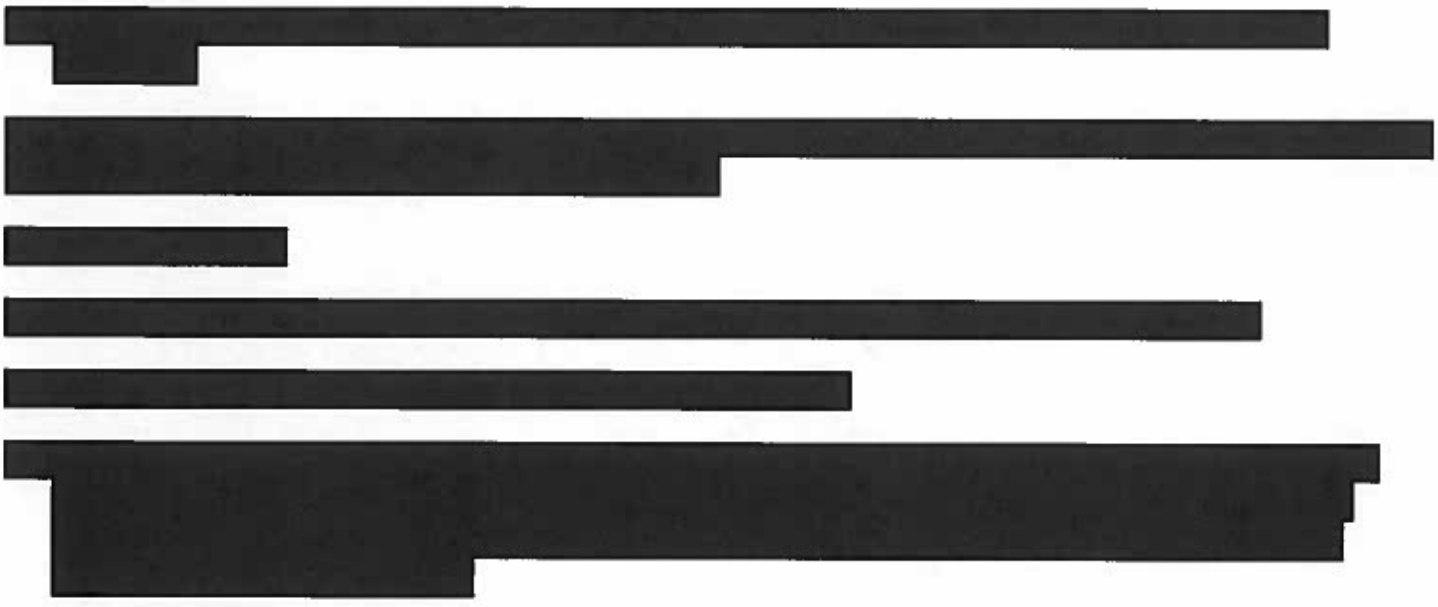

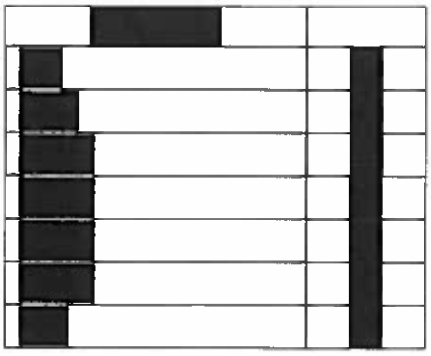

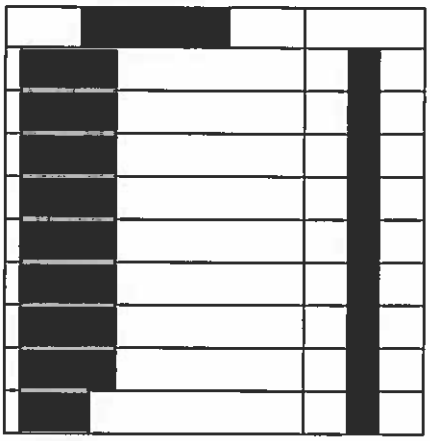

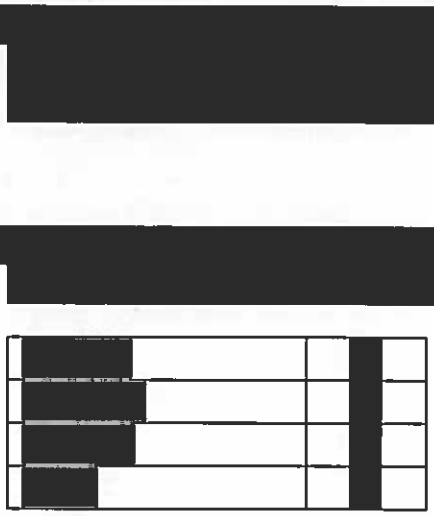

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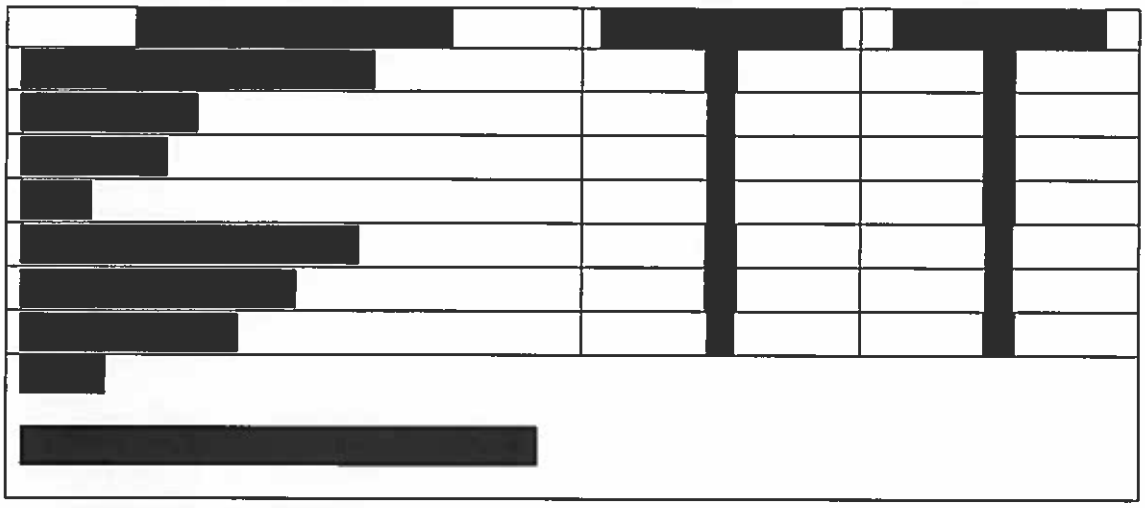

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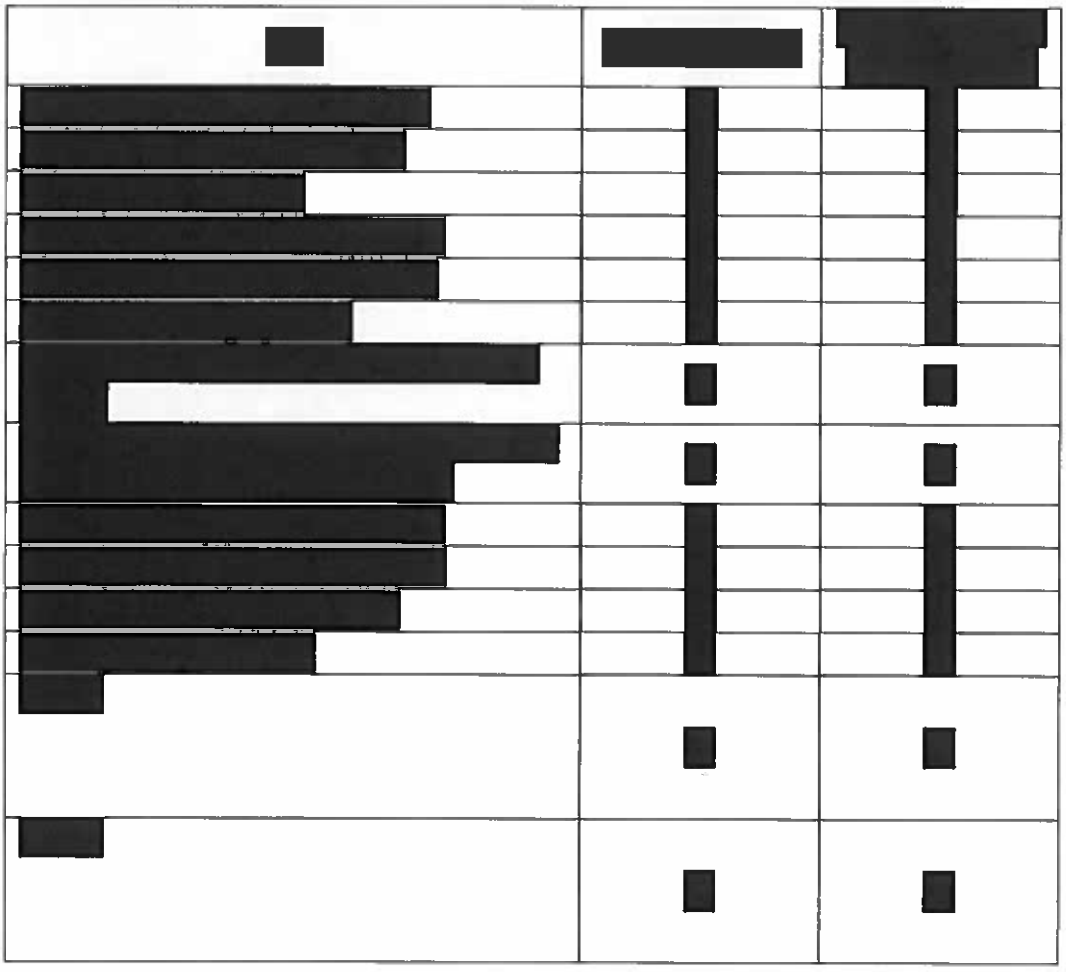

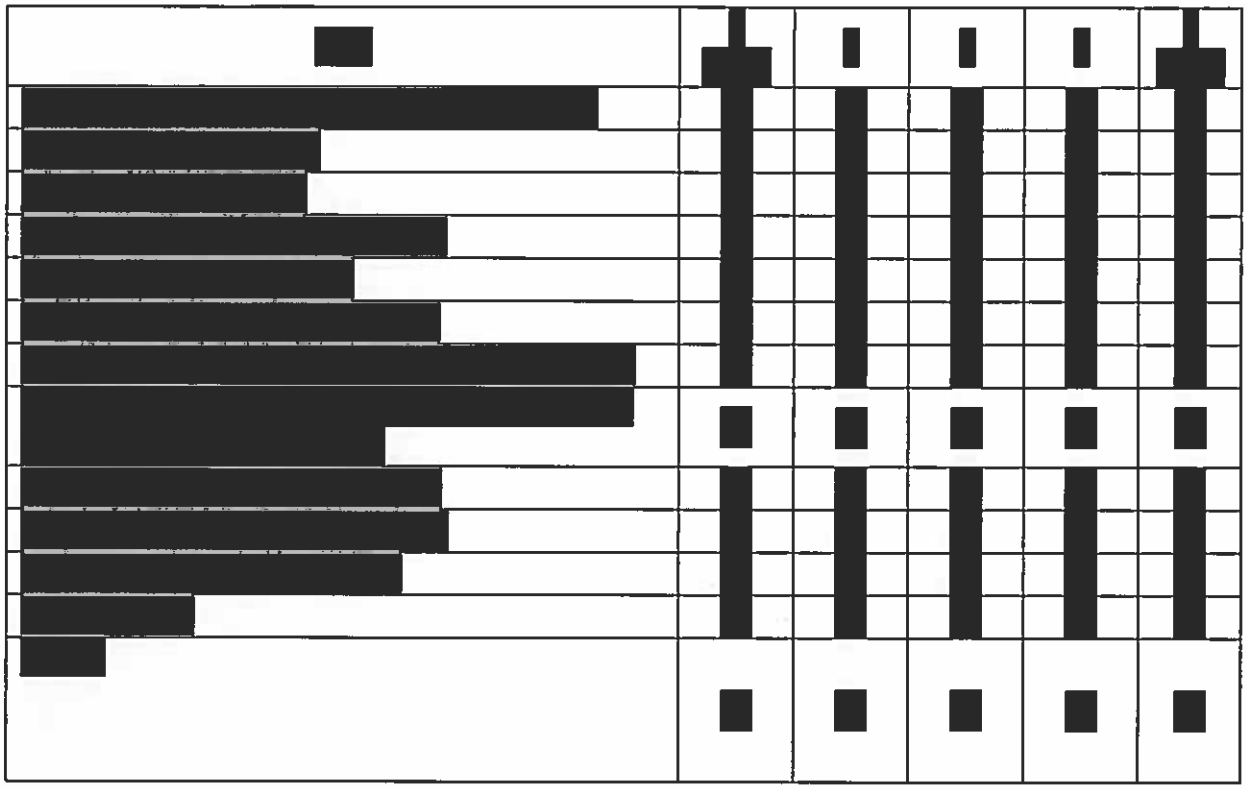

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Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 051

Accepted by: KJDW

Notes: Standard cover sheet added;

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

ACC Request for Information

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Edward C Maynard MD

Location:

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Iron Horse Pediatrics

Location: 555 East Pikes Peak Ave Ste 200

Colorado Springs CO 80903

☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty:
  ii. Area of practice: Pediatrics
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Member of Region 7 RCCO community advisory committee; practice contracted with the RCCO, including for care coordination

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Primmary care provider

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely x
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Are you currently involved in the ACC program?

Please feel welcome to describe why or why not using the space below.

☐ Yes x
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years x
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.
- The decision to make the well child visit one of the KPIs is a good one
    - Support for care coordination is helpful
- Support for integrated behavioral health in the medical home will be helpful

2) What is not working well in the ACC Program?

- Patients continue to be attributed to the wrong medical home, and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.
- The 5DAC data does not reflect the data in our EHR. The RFP should ask the RCCOs to take advantage of practice-based data.
- Feedback from RCCOs to the medical home regarding care coordination would be helpful.
- **Behavioral Health Integration**

7) What should be the next steps in behavioral health integration in Colorado?[1]

- Open the behavioral health and wellness codes (96150 – 96155) to encourage integration

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home.

- The CPACK program developed by CBHC provides:
  a. Assistance with finding a behavioral health provider
  b. Telephone consultation with a child psychiatrist
  We recommend that BHOs be required to provide these 2 components as part of their new contracts.

- Payment options for integrated behavioral health need to be clear and understandable to providers and practices.

- ***Care Coordination***

Question 12) What needs for children/families should be coordinated in medical homes and are there services that should not be a part of care coordination by the pediatric and family medical home

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs can help with such needs as housing, food, parental employment, and child care, usually by helping families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Where should care coordination be done?

Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good care and for cost savings.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill?

The overall goal of Colorado Medicaid should be to provide care coordination services for all patients in the Medicaid.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard

examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They should include PCMPs in developing those criteria.

- All RCCOs should help medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- RCCOs should be required to help medical homes check which patients have been attributed the medical home, and assure accurate attribution.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and shared savings incentives, and provide the medical home with comparative performance data.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is applicable to the Denver metro area, not our Region 7.

27) Should the RCCO region maps change? Why or why not? If so, how?

Region 7 seems to be working well.

28) Should the BHO region maps change? Why or why not? If so, how?

In Region 7 the BHO region already conforms to the RCCO region, and the two systems have been fully integrated from the start.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

n/a

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The RCCOs should work with each medical home to be sure patients are correctly attributed.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- Medical homes need to receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.
- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.
- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully. Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation.
- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.
- The data system would have to be able to report real time data and be far more accurate than it is now.
- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.
- The incentive system should be developed and reviewed by providers before implementing capitation

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Appropriate child health measures could be selected from the following measures :
  - Well child visits appropriate for age
  - Developmental screening from age 6 months to 5 years
  - Teen depression screening
  - Complete immunization status by age two
  - Appropriate antibiotic use in URI and strep pharyngitis
    Patient (or family) satisfaction ratings
  - Documentation of QI projects

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 052

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Kathleen Patrick, Lynn Jenkins Nygren, Paula Chelewski, Elizabeth Clark, Pam Brunner Nii
Location: Denver, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Department of Education
Location: Denver, CO
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☒ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☐ Yes
☒ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Outreach and Enrollment of students and families in Medicaid, School Health Medicaid Program

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☒ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Schools are not currently part of the medical neighborhood but the potential is there for the contribution of the school nurse to provide prevention and education in the school setting.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

Improved access for enrollment with the Connect for Health Colorado

2) What is not working well in the ACC Program?

Barriers to care for children, especially in the rural areas, is still occurring in regards to limited provider networks, families how to access system, understand benefits.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

Improved parity of physical and mental health, increased awareness of mental health issues.

4) What is not working well in the BHO system?

Confusing system – who is responsible for providing services. School Outreach specialists is not defined and underutilized. BHOs are not aligned with RCCOs. Not enough providers. Barriers to services could be improved by providing services in the schools.

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Unsure about confidentiality and ability to coordinate care.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Needs to be a task force at a state level and eventually at a regional level to determine the needs of the patients and communities at a local level. There needs to be a sustainable partnerships between schools and BHOs to provide services.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☒	☐	Services need to be provided in the community and not just in the BHO office
Privacy Laws (HIPAA, 42 CFR)	☒	☐	FERPA and HIPAA
Professional / cultural divisions	☒	☐	Integrate physical and mental health. 30% of students that present in a school health room has an underlying mental health issue.
RCCO or BHO contracts	☐	☐	
Staff capacity	☒	☐	Not enough qualified providers to provide services. Waiting lists are long. Lack of bi-lingual providers. Improve training and better utilize of professionals including the schools
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Training	☐	☐	
Others	Services need to be provided where the patient is working, living, attending school so that access is improved.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

For each visit, they get a contact with a physical and mental health professional. Universal screening and referral needs to be done at every visit. Care should be patient driven and respect for autonomy and cultural differences.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Schools are a hidden health care system that are underutilized and not valued as a member of the healthcare community. School nurses are trained in assessing the behavioral health of children. They have the additional strength of being a healthcare professional and thus can facilitate the integration of physical and mental health.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

Right care at the right time and avoid unnecessary duplication of services.

b. How should RCCOs prioritize who receives care coordination first?

High needs or those who over utilize the system

c. How should RCCOs identify clients and families who need care coordination?

Identify the patient in the medical home – criteria developed, using data on utilization, and patients identified in their medical home.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

Electronic health records for better communications among providers including the school health system so all providers are aware of current

12) What services should be coordinated and are there services that should not be a part of care coordination?

All services

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

Everything mentioned in #15 – comprehensive health and social history important.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

Depends on what system the child/family is in. 'Struggling families tend to have difficulty obtaining primary prevention care, so sometimes the school nurse is the one that works with the parent in directing and navigating them through the medical system

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

Schools and school nurses have access to students and families and are providing care coordination every day without any additional financial support.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

Recognize that many school nurses are providing care coordination and importance of allowing for communication between providers.

d. What are the gaps in care coordination across the continuum of care?

Good communication

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	Should the RCCO have a role? No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☒	
Affordability (assistance with prescriptions or co-pays)	☒	☐	☐	
Daycare / childcare	☐	☐	☒	
Economic stability & employment	☐	☐	☒	
Education	☐	☐	☒	
Environment	☐	☐	☒	
Food access / nutrition	☒	☐	☐	
Health literacy	☒	☐	☐	
Housing	☐	☐	☒	
Language or translation services	☒	☐	☒	

Literacy	☐	☐	☒	
Transportation	☐	☐	☒	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	

Psychologists	☐	☐	
Registered Nurses	☒	☐	
Social Workers	☒	☐	Medical social workers
Wraparound facilitators	☐	☐	
Other	All have a role but the professionals that should be providing the major coordination would be nurses and social workers who have been trained in providing care coordination. School Nurses could be trained in the Navigator role.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☒	
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☒	☐	
Children involved in the foster care system	☒	☐	
Children with a chronic illness	☒	☐	
Children with a serious emotional disturbance	☒	☐	
Children with medical complexity	☒	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	
Transition-age adolescents	☐	☒	
Parents and families	☐	☒	
Pregnant women	☐	☒	
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☒	☐	
Adults with a chronic illness	☒	☐	
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	
Clients involved in the criminal justice system	☒	☐	
Clients with a disability	☒	☐	
Clients in a nursing facility	☐	☒	
Elderly clients	☐	☒	

Frail elderly clients	☐	☒	
Clients in palliative care	☐	☒	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

Partnering with schools and childcare agencies with identified outcomes would address the needs of medically and socially complex children including foster children.

19) How should care coordination be evaluated? How should its outcomes be measured?

Care coordination can be evaluated with progress towards outcomes which should be measured through cost savings and improved health of participants. There should be a cost benefit analysis.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

The benefit of increasing the PMPM for behavioral health and medically complex children would promote additional services within community agencies.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

It should vary depending on the complexity of the child

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐

1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

Steady progress in cost savings, shared EMR, improved health outcomes for children and patient/provider satisfaction

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Involved health providers in community agencies where children with special healthcare needs are located such as schools, daycares, preschools.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Data reporting to and from the RCCOs, payment methodologies, and standardization. RCCOs were designed to ensure that every member receives care coordination but children by and large are not receiving these services.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Development of a community advisory board that represents the divers population within the community including school staff such as school nurse, counselors and administrators.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

Relationships already exists in many communities by stakeholders and having competition between RCCOs would improve the program.

27) Should the RCCO region maps change? Why or why not? If so, how?

RCCO and BHO should align!

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

More ability to connect stakeholders and invite divers populations to discuss needs and outcomes.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

School include schools beyond the School Health Medicaid Program.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues

would this address? Competition improves standards and reduces cost. Modeling of highly effective RCCOs would significantly add to improving outcomes.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

Schools could be Medicaid provider beyond School Health Program as it is limited to Medicaid Children with Special Education Services that require Medicaid billable services. We are looking from a health frame of reference. 10% of students receive special education services with a smaller percentage of which are Medicaid eligible.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

Providing communication pathways between all providers and community points of access.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

All programs that provide similar or the same types of services for population health should be better coordinated

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

Same as 35

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

Facilitating provider and agency education about services and education to improve health literacy of community members

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

There should be coordination where applicable but definitely there should be (possible advisory council) increased communication about community and regional gaps in services and how to address individuals in transition with job changes, etc

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

Client's and families need to have an equal seat at the table in terms of needs and this should include cultural considerations, including language. Providing health education and literacy first is key as well as some training in self-advocacy and civic leadership.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

Requirements should be a facilitation of opportunity to speak to regional needs and should encourage innovation at the simplest level to the top of the organization. RCCOs should engage all interested parties.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

Policy creation should include all stakeholders.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Again, this collaborative should be driving thoughtful strategic planning that addresses real issues and needs that are regional and does not depend on only the healthcare industry and insurance industry for ideas to promote health and prevention of illness.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

Data reflects this is a resounding no, especially in the rural regions. However, there needs to be more real collaboration between mental and behavioral health, primary care and these services, and alternative and health promotion practices—so that effective care is provided, with continuity across the care continuum. This should include the hidden system of care that is the school system.

Secondly, more assistance with navigating the systems is needed, and more trained professionals (interprofessional education) in higher education to develop a competent and collaborative 21st century workforce.

a. If no, what are the gaps?

Pediatric mental and behavioral health is the highest needs. Also, ratios in schools are unsafe with respect to school health care professionals. Acuities are higher than ever before and the educational system is not prepared to meet those needs with the existing levels of funding. Colorado's ratio for school nurse to student is 1800:1. Healthy People 2020 recommends 1 school nurse for every 750 healthy students.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

See above

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.
All of these should be viewed across a developmental spectrum of care—and these are all a type of primary care that assumes different shades of service depending on the place in the lifespan of an individual. We need to function across these stages as a whole, and figuring out how to do that with efficiency and quality is the real question.

a. What role should hospitals play in the next iteration of the ACC Program?

Hospitals are a part of the acute system of care and should be included in the care coordination model.

b. What role should pharmacies play in the next iteration of the ACC Program?

Pharmacies should focus primarily on education and assisting individuals to safely and effectively manage their medication regimens. They should be more regulated in terms of dispensing of pediatric medications and narcotic pain medications.

c. What role should specialists play in the next iteration of the ACC Program?

Specialists are key to the overall care system and need to be considered equal partners in coordination and also, carry equal responsibilities for communicating patient needs and for driving innovative educational methods including telehealth

d. What role should home health play in the next iteration of the ACC Program?

Home health is another part of the spectrum of care, and should be included in the care coordination model as well as in the health information and electronic transfer of information

e. What role should hospice care play in the next iteration of the ACC Program?

Same as above

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

Again local government and this includes county leadership should be at the table.

h. What role should local public health agencies play in the next iteration of the ACC Program?

They are a level of primary care in essence and fill certain niches that are prevention and population health focused.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

Definitely—school districts, non-profits and faith based organizations can and do provide many services and provide a safety net for many who would otherwise go without health care services.

45) How can RCCOs help to support clients and families in making and keeping appointments?

By building relationships at the individual, family, provider and community level. Specifically, navigators (all levels) are instrumental in this area. Navigators function as a bridge and glue for the patient and family who are struggling in one or more areas of life (social, emotional, physical, spiritual, mental). Also helping address any barriers such as transportation or childcare.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

No, they should not be required, but rather a system that provides more incentive for better coordination and patient satisfaction as well as health outcomes could be the result of navigator services. Schools are a place that could provide staff that is already fulfilling the community health worker role.

47) **Community Health Worker reimbursement**. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☒
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☒

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

Regular visits for oral health should be a component of the follow-up RCCO's provides. Rural areas need additional support and resources as they lack providers.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

Cultural sensitivity is at the most basic level understanding that health itself means very different things to many cultures and ethnic groups. It is at the base level acknowledging the need to be sensitive to and aware of differences and respecting those. Cultural competence is an ideal that can hardly be maintained at all systemic levels because it would require too many large system changes. However, it is important for organizations and individual providers to be aware of the population they are primarily working with and take the time to learn about the various cultural practices and beliefs, and incorporate this across the organizational structures they are in contact with--

b. What RCCO requirements would ensure cultural competency?

Again, there should be incentives not requirements.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

Language interpreters and bilingual/multilingual staff are key as well as materials in various languages and at literacy levels that are conducive to understanding. Training for ALL staff on the various relevant cultural origins of their patient populations. General training in patient centered practice and team-focused care as well as motivational interviewing and caring communication to that facilitates relationship building from the time the patient enters the building/organization until they leave. And a caring system of follow up that speaks to respecting the patient's autonomy as well as their decision making.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

It would be more productive to allow for organizations and systems to assess their needs and plan for meeting these with the understanding that incentivizing this rather than requiring certain elements would be more productive and promote innovation.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

Yes with very specific expectations of health literate appropriate induction/education of all 'clients' in accessing care.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Yes with very specific expectations of health literate appropriate induction/education of all 'clients' in accessing care.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Alerting the public to challenges and obstacles to care related to ACC. Just like there are road signs warning of pending road construction and slow down, there needs to be guidance to the public about anticipated slow-downs and alternative routes to care access.

Practice Support

54) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☒	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☒	☐	☒	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☒	☐
Provide practice-specific data reports	☒	☐	☒	☐
Provide clinical care guidelines and best practices.	☒	☐	☒	☐
Provide clinical screening tools	☒	☐	☒	☐
Provide health and functioning questionnaires	☒	☐	☒	☐
Provide chronic care templates	☒	☐	☒	☐
Provide registries	☒	☐	☒	☐
Offer client reminders	☒	☐	☒	☐
Offer client self-management tools	☒	☐	☒	☐
Offer educational materials about specific conditions	☒	☐	☒	☐
Supply behavioral health surveys	☒	☐	☒	☐
Supply other self-screening tools	☒	☐	☒	☐
Administer behavioral health surveys	☒	☐	☒	☐
Administer other self-screening tools	☒	☐	☒	☐
Prepare client action plans	☒	☐	☒	☐
Provide training on providing culturally-competent care	☒	☐	☒	☐
Provide training to supporting staff	☒	☐	☒	☐
Provide training on motivational interviewing	☒	☐	☒	☐
Provide tools and software for phone call and appointment tracking	☒	☐	☒	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☒	☐
Provide referral and transitions of care checklists	☒	☐	☒	☐
Provide visit agendas or templates	☒	☐	☒	☐
Provide standing pharmacy order templates	☒	☐	☒	☐
Provide comprehensive directory of community resources	☒	☐	☒	☐
Provide directory of other resources	☒	☐	☒	☐
Provide materials regarding Nurse Advice Line	☒	☐	☒	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

55) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

The RCCO's should develop or follow national or international standards like the Colorado Health TeamWorks collaborative that defines standards of practice making evaluation of the RCCO's care much easier to evaluate.

56) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

Customer sotisfoction surveys ond outcome torgets for common chronic conditions.

57) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

First the Deportment should require consistent evidence bosed guidelines be employed ond once estoblished begin utilizing diseose registries.

58) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

First the Deportment should require consistent evidence bosed guidelines be employed ond once estoblished begin utilizing diseose registries.

59) Please share any other advice or suggestions about provider support in the ACC.

A residency or internship progrom for oll providers in the ACC ensuring odequote role performonce.

Payment Structure and Quality Monitoring

60) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

Schools ore the lorgest pediotric heolth core institution for children yet hove the greotest dispority for poyment structure.

61) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

Not o PCMP but con envision copitotion poyments would support preventive heolth services occess.

62) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

63) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

School heolth core providers licensed os o Limited Service license Provider network hos the potentiol to bring in much needed relief for heolth services currently provided without reimbursement.

64) What role – if any – should the RCCOs play in the distribution of payments to providers?

Monitors of the reimbursement process.

65) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

66) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

Meosures thot ossess the Triple Aim- improving the quolity of core, sotisfoction of clients ond providers, ond heolth core outcomes for common chronic heolth conditions.

67) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☐	☐	
Focus groups	☒	☐	
Other	Please type your response here.		

68) Knowing that, at this time, the Department only has claims data, how should population health be measured?

Claims data address primarily medical care in response to a problem.
To change to a Prevention and Health Promotion focus, new measurements must be implemented that consider the time needed for behavioral change (year instead of month), barriers to change (access to resources, transportation, time from work, cultural, and language) and the response of the client. For example,

- percentage of client with a medical home or similar health support services that encourages preventative and health promotion
- referrals to programs that requires monitoring and ongoing education between provider visits
- patient and provider developed plan of care (success has been documented using Motivational Interviewing for diagnosis like obesity prevention and medication adherence)
- follow up questionnaire that looks at behaviors that will increase life span and decrease use of services (like medication adherence, dietary modification, increased activity

69) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

Bi-annual reports

70) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

71) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

If the measure or performance indicators continue to be medically based, then a low percentage. If the indicators are Prevention and Health Promotion based, then 50%. Access to care should be easier for the client for Prevention and Health Promotion with only urgent care allowing easy access. The client in a person centered care system needs to take responsibility for decreasing the cost and increasing the effectiveness.

72) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Yes . the same general category of KPI can be used.
and No. The strength of the RCCO is that it is regionally based, so the strengths and barriers of each region will be different. Providers should have incentives to care for the clients who use the most resources, but who will have to most barriers to care. Providers should not be penalized for caring for client with the most difficult-to-change indicators of health.

73) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

There should be a general alignment with national standards with a modification to regional issues. Improvement should be included but it should be measured on what the providers can change.

74) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

Payment should be tied to short term interventions that would reflect urgent care, reasonable medical interventions, and regular medical care.
Additional payment can be made for annual improvements to health.

75) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below

76) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

77) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

78) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☒
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☐	☒
Smartphone app	☐	☒
Other:		

79) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

80) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the 5DAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☒	☐	☐	☐	☐
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☒	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☒	☐	☐	☐
Health risk assessment software	☐	☐	☐	☒	☐
Practice management tools (scheduling, billing)	☐	☒	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☒
Patient education wellness tools	☐	☐	☐	☒	☐
Provider/case manager directory	☐	☐	☐	☐	☒
Shared decision-making tools	☐	☐	☐	☒	☐
Telemedicine	☐	☐	☐	☐	☒
Other:	☐	☐	☐	☐	☐

81) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

We need to overcome the barriers of HIPAA and FERPA so that school nurses can communicate effectively with providers and have access to EMRs to be able to provide continuity of care.

82) How can Health Information Technology support Behavioral Health Integration?

Behavioral health should be a part of EMR so that providers are looking at the whole child.

83) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

84) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

There should be only one care management tool that all providers work from.

85) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

86) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

Major limitation in the rural areas is identifying providers that will take Medicaid. Are there any providers in the urban areas that are willing to visit the smaller towns or participate in telemedicine.

87) How can the RCCOs support providers' access to actionable and timely clinical data?

School nurses should have access to EMR of select students to be able to provide continuity of care.

88) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

There needs to be shared access to better communicate care.

89) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

They can work with the schools/ school nurses so they can have access to health information.

90) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

There needs to be a single platform that all providers can access to obtain health information.

91) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 053

Accepted by: KJDW

Notes: Standard cover sheet added;

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Katherine A. Price
Location: Grand Junction, Mesa, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Western Colorado Pediatric Associates, a division of Primary Care Partners
Location: Grand Junction, Mesa, CO
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Pediatrics
  ii. Area of practice: Mesa County – inpatient and outpatient services
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☒ 1-2 years
☐ 2-3 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:

I see patients who are in the ACC program. I interact with our RCCO to try and better understand the program and provide services to our patients.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

I have been a Medicaid provider for the last 14 years, first in Utah, then California and now Colorado.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

I, and my practice, are committed to providing care for children on Medicaid in Western Colorado.

☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

There is a renewed understanding of the importance of the primary care provider being the center of the medical home. There is also understanding of the importance of coordination of care and there is an attempted focus on preventative care.

2) What is not working well in the ACC Program?

There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level.

It does not seem like there is a system built in to account for the mobility/churn of patients on/off Medicaid and between RCCOs. Whether it be KPIs or future shared savings marks, seems like practices need to be judged on the patients who have been under the influence of the practice for a min 6 months (otherwise there is quite a bit of disincentive for practices to be open to the more complex/challenging patients... those that likely need access the most).

3) What is working best in the Behavioral Health Organization (BHO) system right now?

Not much at all.

4) What is not working well in the BHO system?

Access is very limited and cumbersome for patients and providers. There is very poor communication between our BHO and our RCCO and our PCMPs. Payment is not aligned in a way that allows for the right service at the right time

5) What is working well with RCCO and BHO collaboration right now?

Not much, but they are talking, and there is acknowledgement that these programs need to work together to care for patients.

6) What is not working well with RCCO and BHO collaboration right now?

They are separate systems with separate payment models and are still very much separate silos.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

We need embedded counselors and pediatric psychiatric services who do medication management also embedded. We need the BHOs and the RCCOs to be combined under the same program.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☒	☐	
Different behavioral / physical health reimbursement	☒	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☒	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☒	☐	
Staff capacity	☒	☐	
State/Federal rules or reporting requirements	☒	☐	
Technical resources / data sharing	☒	☐	
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

Site visit and chart review by knowledgeable staff that understands the concepts of integrated, whole-person/whole-family physical and behavioral health care.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

There needs to be a model and a culture on the behavioral health side of care that care providers form long-term relationships with patients, and not a culture of plug and play. There needs to be less turnover of behavioral health providers.

Care Coordination

11) Care coordination is an important part of the ACC Program.

Care coordination should be done in our PCMPs practice. Because, the patients know us and we know them. The patients trust us. We (the Medicaid medical providers) are the most stable/consistent provider/player/entity in our area.

We are very willing to provide this care in our office, because we have a relationship with our patients and they trust us and we recognize how important coordinating complex medical care is essential for good care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues. Primary care providers are also best positioned to be connected to local community resources specific to their area.

a. What is the best definition of care coordination?

b. How should RCCOs prioritize who receives care coordination first?

c. How should RCCOs identify clients and families who need care coordination?

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

If you are willing to do care coordination in your practice, how much money do you need as a pmpm to make the program work for your patient panel?

An ongoing rate of $6-7pmpm once care coordination programs are up and running, with an initial period of investment at $10 pmpm, because establishing these services requires even more resources initially.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill?

The overall goal of Colorado Medicaid should be to provider care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventative medicine and care coordinator are very well positioned to help identify risk factors proactively, before, potentially before they impact a patient's health and cause illness.

If your practice provides care coordination how should your care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists to account for risk. The program should be measured by how far the practice is down the path of practice transformation (including, but not limited to how well the practice is connected to its medical neighborhood, closing the loop on the referral process, how established the programs is with community resources and other community agencies). Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

12) What services should be coordinated and are there services that should not be a part of care coordination?

Services that should be covered: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), mental/behavioral health, schools, early intervention services, other agencies (rehab, hospice, ...), foster care and DHS system.

Services that should not be part of care coordination (except for rare circumstances): assistance with housing, food, parental employment, child care. But care coordination should help families connect with other agencies that provide these services.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	Should the RCCO have a role? No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☐	Embedded mental health
Affordability (assistance with prescriptions or co-pays)	☒	☐	☐	Education on generic medications, complex pharmacy med management
Daycare / childcare	☐	☒	☒	
Economic stability & employment	☐	☒	☐	
Education	☒	☐	☐	Coordination with school based services
Environment	☐	☒	☐	
Food access / nutrition	☐	☒	☒	
Health literacy	☒	☐	☐	Care coordination, personal health coach, motivational. This is key for long term cost savings!!
Housing	☐	☒	☒	
Language or translation services	☒	☐	☐	
Literacy	☐	☒	☒	
Transportation	☐	☒	☒	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	
Certified Addiction Councilors	☒	☐	
Certified Nurse Midwives	☒	☐	
Community Health Workers	☒	☐	
Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☒	☐	
Licensed Mental Health Counselors	☒	☐	
Licensed Professional Counselor	☒	☐	
Masters of Public Health	☒	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	
Nurse Practitioners	☒	☐	
Patient Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☐	☐	??
Psychiatrists	☒	☐	
Psychologists	☒	☐	
Registered Nurses	☒	☐	
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

No, there are big gaps in access to specialists and mental health services. Also, there are not enough PCMPs in our area. Our patient panels are too big to provide appropriate and timely access to care.

What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

They should absolutely play a role so that resources can be better allocated and there is not so much overlap of services without communication between resources.

How can RCCOs help to support clients and families in making and keeping appointments?

Provide enough funding for practices to have care coordinators who can help identify barriers. And the RCCO program needs to find a way to hold patients accountable for making and keeping appointments.

Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Health Information Exchanges must work to feed ER info back into the PCMP. Also, patients need a financial disincentive for using the ER for ambulatory sensitive conditions. And the RCCOs need to find a way to help improve after-hours access for patients to appropriate, quality non-ER services.

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

    a. What is the PMPM cost for providing care coordination services?

    b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☒
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and in what parts of the state? What issues would this address?

I am not sure that multiple RCCOs in one region would be helpful. For as complex as the RCCOs are already, I think that would add even more confusion for practices and patients.

How involved are you with the RCCO? How willing are you to be involved with the RCCO? What do the RCCOs need to do to get you interested in getting involved?

It would be beneficial to have some coordination/communication of subpopulation groups within and between the RCCOs (for example pediatric practices).

What is working well with the RCCOs?

There is momentum for practice transformation.

What is not working well with the RCCOs?

There is not enough funding via pmpm for practices to make the necessary changes to move from a FFS model to a value based payment or ACO model.

Payment Structure and Quality Monitoring

Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

No. The pmpm is too low to change much. Also, the KPIs need to remain focused on process not outcomes until the data is more sophisticated to account for risk factors and where patients start.

Right now medical homes don't get rewards for good outcomes (KPI), unless the whole RCCO has the good outcomes (KPI). Is this fair? Or should a practice get rewards for good performance no matter how well the RCCO does?

No, it is not fair. Rewards for good outcomes (KPIs) need to be at the practice level, because that is their sphere of influence, not the entire RCCO.

If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

No, the underlying foundation is not in place yet.

Measurement / Evaluation

What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

Vaccination rates (with patients who were offered, counseled on the importance and declined count and patients who have contraindication count).

24) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

25) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

26) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

27) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

28) What role – if any – should the RCCOs play in the distribution of payments to providers?

29) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

30) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

31) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

32) Knowing that, at this time, the Department only has claims data, how should population health be measured?

33) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

34) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

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8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

35) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☒
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

36) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

37) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

38) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

39) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☒
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 054

Accepted by: KJDW

Notes: Standard cover sheet added;

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

ACC Request for Information

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Kelly Phillips-Henry, PsyD
Location: Colorado Springs, CO 80903

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: AspenPointe
Location: Colorado Springs, CO 80903
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☒ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☒ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:

AspenPointe was one of the founding member organizations for RCCO 7 which is part of Community Health Partnership, a not for profit collaborative organization of healthcare agencies. Currently, AspenPointe is significantly connected to RCCO 7: we contract with RCCO 7 to operate the Service Center, manage the provide network as well as provide back office/data functions. Additionally we participate in multiple pilots that connect physical health to critical behavioral health services including coordination of care supports for shared RCCO/BHO patients, training care coordinators in RCCO physical health practices in behavioral health issues, and targeted health coaching to activate those with chronic diseases such as diabetes, asthma and obesity to better self-manage their own health and wellness.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

AspenPointe is a behavioral health provider in Southern Colorado that aligns to Colorado Health Partners BHO.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Strong community partnership to deliver care across entire community healthcare system
- Our approach focuses on local solutions to deliver the best health outcomes and care customizable to the needs in our community
- Having multiple RCCOs that all have a focus on shared decision making for their unique communities has been very effective.

2) What is not working well in the ACC Program?

- While service delivery and coverage expansion has made significant progress since the inception of the ACA , payment reform still lags.
- There has been little movement in impacting quality care metrics and bending the cost curve.
- Until the state is ready to move away from Fee For Service (FFS) and move towards paying for outcomes/quality care, the RCCOs will only have marginal success achieving all parts of the Triple Aim.
- Cost, quality and outcomes must all be emphasized.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

The State of Colorado has been a strong leader and model for the nation over the past 20 years as it relates to the management and delivery of Behavioral Health services. Instead of operating in a system that emphasizes volume through a fee for service system, Colorado has been progressive in their approach by moving to a capitated, risk-based approach for an entire population of people. Risk stratification, expansive access, management of expensive clinical care with best practice clinical pathways and a strong emphasis on taking care back into the communities has allowed for significant statewide savings and better care outcomes. With over 20 years of experience in this risk-based model, which is a fundamental component in any payment reform initiative, the BHOs have figured out how to manage provider risk. This skill set can be scaled to accomplish similar outcomes across all of healthcare.

4) What is not working well in the BHO system?

Even though the BHOs have operated in a managed, risk-based contract for decades, over the years this model has continued to emphasize encounters and retroactive fee for service accounting continues to take place. To be successful in healthcare delivery moving forward, HCPF will need to plan for a system that reimburses strong, performance-based outcomes.

5) What is working well with RCCO and BHO collaboration right now?

- The RCCO/BHO meetings are working very well at both the state level as well as locally.
- Strong collaboration on care coordination for SPMI and SED patients.
- Many pilot opportunities to demonstrate enhanced ways to maximize population health information and risk stratification for the shared Medicaid populations.
- C-PACK, the child psychiatric consultation model, has been an excellent resource to local pediatricians.
- Sensitivity in planning and delivering care to address local solutions – this should remain a critical feature for next round of RCCO bids. Additionally, because our response is local, we pull in many ancillary supports that impact total health outcomes – including the Health Department, social service agencies, emergency response agencies and law enforcement.
- Through improved and ongoing communication there is an increased awareness of the role that behavioral health plays in the holistic care of individuals

6) What is not working well with RCCO and BHO collaboration right now?

- We believe that progress towards payment reform is way too slow.
- We believe that the BHOs & mental health centers should be included in receiving SDAC data to best coordinate care across our shared population.
- Care coordination needs to be expanded to the whole population – not just high-utilizer patients. The BHOs/MHCs could provide much greater supports to this cause.
- Many RCCO practices believe that only a psychiatrist can help with behavioral health conditions or life style change factors for patients that struggle with chronic disease conditions. Our continuum is very large and supports could be utilized in a much more expansive manner.
- Similar to above, many RCCO practices believe that integration with MHCs is only achieved through implementation/co-location of Behavioral Health Consultants (BHCs). However, the continuum offered through MHCs is broad and supports beyond BHCs could be utilized in a much more expansive manner.
- We believe that MHCs should be able to be PCMPs and credentialed/paneled into the RCCO PCMP network (including the pmpm care coordination payment) for patients who see the MHC as the primary source of their care.
- While there is an awareness that behavioral health contributes to many of the challenges in managing high cost complex patient, there is still a disconnect on how and where along the full care continuum it is most effective to partner and link with BHO to successfully co-manage these cases

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

First, as alignment continues between the RCCO and BHOs, the RCCO RFP should continue to emphasize further integration of programs, data and finances to meet goals related to the development of health homes and person-centered care, as well as finding further efficiencies. RCCOs that can demonstrate continued movement in this direction should be awarded with higher scores on RFP scoring.

Second, the Colorado State Health Innovation Plan is critical to the advancement of healthcare integration in Colorado. Bringing together stakeholders from multiple disciplines to create a centralized platform to best deliver care and track both the data and finance on the back end is critical. Feedback from the medical community, behavioral health community, social services, and educational fields need to be included.

Third, to truly allow behavioral health to integrate into physical health, the alignment of government funding streams must occur. Funds from HCPF (Medicaid) and OBH must work in tandem to allow for comprehensive care of patients as well as achieve population health goals moving forward.

Fourth, to provide comprehensive care, we must continue to move away from a fee for service system, which emphasizes volume, and move towards a risk-based payment model where comprehensive care utilizing advanced techniques such as risk stratification, produces stronger clinical and financial outcomes. The greatest buy in towards this model will happen when HCPF incentivizes providers to assume and manage this risk.

Fifth, as we move further into integrated care planning for people with multiple, complex health needs (i.e. intellectual and developmental disabilities, organic-based dementia care and traumatic brain injuries), we encourage HCPF to utilize BHO/MSO experience since they have been successfully providing risk-based population care for years.

Sixth, creating enough flexibility in the billing and reporting systems to distill specific types of encounters in organizations that are hosting behavioral healthcare providers but not hiring those providers directly.

Lastly, we encourage HCPF to consider enhancing the existing Medicaid SUD benefit to a full continuum of care, including services in parity with those offered for mental heat6h and physical health (such as intensive outpatient, partial-hospitalization and inpatient / residential treatment services) to produce better health outcomes and lower costs over time.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services. Using the table below, please explain which issues are barriers, and how they can be addressed:**

Factor:	Barrier? Yes	Barrier? No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☒	
Community Behavioral Health Services Rule	☐	☒	
Covered diagnoses list	☒	☐	If there was not a limited diagnosis set, it would allow for much more comprehensive services to be provided to patients in a physical health setting.
Different behavioral / physical health reimbursement	☐	☒	Right now we cannot bill physical health in the behavioral health setting so we are not able to run primary care unless we become an FQ. Also physical health is incentivized by FFS and we are not, so the billing mechanisms do not align.
Institutions for Mental Diseases exclusion	☒	☐	IMD continues to be a barrier for expanded services to meet local population needs. While the 1915 (b) waiver through the Medicaid managed Care program offers some flexibility, the risk of how our waiver could be interpreted by the Feds have prevented many service expansions from occurring in our community.
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	Better alignment in licensing and compliance standards between OBH, HCPF and CDPHE could assist with streamlined standards and service provision process for approach by state agencies
PCMP financing structure	☐	☐	Don't understand well enough to add input here
Per-member per-month amount	☐	☒	
Physical space constraints	☒	☐	Locally we are looking for additional solutions for expanded space for primary care in the MHC (bidirectional care). As 2703 continues to be considered in Colorado, this will remain an important area to address.
Privacy Laws (HIPAA, 42 CFR)	☒	☐	42 CFR is a real problem for care coordination and a barrier to ensuring the best care is delivered to patients; HIPPA is not as much of a concern

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Professional / cultural divisions	☒	☐	As the primary care and behavioral health fields continue to come together and integrate, professional and cultural divisions is something we will need to continue to bridge. The BHO and the MHCs have very rich experience in this area that can be utilized to bring the two fields closer together.
RCCO or BHO contracts	☐	☒	
Staff capacity	☒	☐	Work force issues and staff capacity is an issue nationally for all of healthcare. We have an aggressive state and local recruiting strategy to bring in specialists in the behavioral health area.
State/Federal rules or reporting requirements	☒	☐	The reporting requirements need to be aligned across state agencies
Technical resources / data sharing	☒	☐	For best continuity of care, SDAC data needs to be shared with the BHOs
Training	☒	☐	While there are national training programs to best train BH specialists to work in Primary Care, the field is still fairly young. Training happens mostly through internship programs and certificate training programs. Very few Masters/Doctorate programs teach to integrated care and even fewer primary care residencies and nursing programs train to how to utilize behavioral health consultants as a part of the medical team. More work needs to continue in this area.
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

We are strong advocates of the SAMHSA 6 levels of integration. This approach aligns with an emerging national standardization of levels of behavioral/physical health integration. It allows for training, research and cross-collaboration while using a similar language and operational approach.

http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf

10) Please share any other general advice or suggestions you may have about behavioral health integration.

We strongly believe that in order to achieve strong integration across primary care practices and behavioral health, the principles of integration need to be agreed to across state agencies and should align across all payors. Only through this alignment will the RCCO, BHO and commercial payors be able to accomplish the goals of Colorado's State Health Innovation Plan. This not only should align services and the integration model (e.g. SAMHSA 6 Levels of Integration Model), but also administrative systems, data, financing, provider needs, and patient needs including social determinants of health, physical and behavioral health needs. Additionally, there are many key populations that still rest in different oversight and funding streams that need to be integrated into our centralized care structure: such as people with autism-spectrum disorders, traumatic brain injuries, and developmental disabilities.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

No answer submitted

b. How should RCCOs prioritize who receives care coordination first?

No answer submitted

c. How should RCCOs identify clients and families who need care coordination?

No answer submitted

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

No answer submitted

12) What services should be coordinated and are there services that should not be a part of care coordination?

- We believe that all services should be coordinated for best outcomes.
- Services should include all medical and behavioral health as well as social services and public health.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

- Care coordinators need to be able to track the care of all patients through their primary care provider, including in bi-directional settings where patients receive both primary and behavioral healthcare in a MHC.
- Specialty services should be assessed through primary care and coordinated.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

- Care coordination is occurring in too many locations and by too many different entities. The RCCO RFP should take the opportunity to streamline this process and provide incentives to RCCOs who can care coordinate complex, multiple systems of care.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

- BHOs are required to care coordinate for BH patients. This sometimes causes major duplication in efforts and at times this care coordination is in direct opposition to each other leading to confusion. THE MHCs have done care coordination for decades and could assist the RCCOs with a proven process.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

- Centralize care coordination under the RCCO

d. What are the gaps in care coordination across the continuum of care?

- No answer submitted

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	Should the RCCO have a role? No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☒	
Affordability (assistance with prescriptions or co-pays)	☐	☒	☐	
Daycare / childcare	☐	☒	☐	
Economic stability & employment	☐	☐	☒	
Education	☐	☒	☐	
Environment	☐	☒	☐	
Food access / nutrition	☐	☐	☒	
Health literacy	☒	☐	☐	
Housing	☐	☒	☐	

Language or translation services	☒	☐	☐	
Literacy	☐	☒	☐	
Transportation	☐	☐	☒	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☒	
Certified Addiction Councilors	☐	☒	
Certified Nurse Midwives	☐	☒	
Community Health Workers	☒	☐	
Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☐	☒	
Licensed Marriage and Family Therapist	☐	☒	
Licensed Mental Health Counselors	☐	☒	
Licensed Professional Counselor	☐	☒	
Masters of Public Health	☐	☒	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☒	
Nurse Practitioners	☐	☒	
Patient Navigators	☒	☐	
Peer Advocates	☒	☐	

Promotoras	☐	☐	
Psychiatrists	☐	☒	
Psychologists	☐	☒	
Registered Nurses	☐	☒	
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☒	
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☒	☐	
Children involved in the foster care system	☒	☐	
Children with a chronic illness	☒	☐	
Children with a serious emotional disturbance	☒	☐	
Children with medical complexity	☒	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	
Transition-age adolescents	☐	☒	
Parents and families	☐	☒	
Pregnant women	☐	☒	
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☐	☒	
Adults with a chronic illness	☒	☐	
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	
Clients involved in the criminal justice system	☒	☐	
Clients with a disability	☐	☒	
Clients in a nursing facility	☐	☒	
Elderly clients	☐	☒	

Frail elderly clients	☐	☒	
Clients in palliative care	☐	☒	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

- The RCCO should be involved if required by their contract – pertaining to medical services.

19) How should care coordination be evaluated? How should its outcomes be measured?

- Due to duplication in care coordination efforts that are currently occurring, care coordination efforts should be measured and tracked. As the overall goal is to decrease overall medical costs, this will be critical in the next RCCO contract.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

- We would recommend consulting with actuarial support as this is not an easy answer. Unfortunately even after pmpm was set, rates were changed which makes it difficult to have a steady plan in place.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

- No answer submitted

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

- No answer submitted

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☒
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐

1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

- Look at quality measures like health outcomes
- Reduction in total cost of care metrics

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

- Care coordination efforts should align with Section 2703 of the AFA for patients with multiple chronic disease states.
- If care coordination is over-regulated, the creativity and flexibility necessary will be eliminated. Assess care coordination success by measuring outcomes, not assessing a RCCOs compliance with box checking.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- Provider contracting allows for a competitive edge that can save money for the state and should be left to the RCCO to manage.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

No answer submitted

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

No answer submitted

27) Should the RCCO region maps change? Why or why not? If so, how?

No answer submitted

28) Should the BHO region maps change? Why or why not? If so, how?

NO – this would immediately lead to another BHO RFP, which does not appear to be the direction of HCPF. We are prepared for BHO maps to change in alignment with RCCOs in the future.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

- We recommend at least 6 months minimum.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

- No answer submitted

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

- Continuous eligibility is important for continuity of care
- 9900 codes that allow integrated sights to provide services that are needed would be a great improvement.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

- I think this is more of a Denver-centric question/issue. I am not sure any part of Southern Colorado would benefit from this arrangement. Having one RCCO allows for the necessary scale to provide care to rural and frontier areas.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

- No answer submitted

34) What role should RCCOs play in attributing clients to their respective PCMPs?

- No answer submitted

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

- No answer submitted

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

- No answer submitted

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

- Somehow figure out how to better manage a patients churning of benefits.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

- No answer submitted

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

RCCOs should be required to continue to utilize the current Performance Improvement Advisory Committee (PIAC) structure to provide input into the contractor's implementation and ongoing management of the ACC program. The PIAC should continue to involve members, client's families, client advocates, and advocacy organizations that interact with mutual members. At least one member of the PIAC should represent the Medicaid-Medicare community in an effort to improve innovation and collaboration efforts for the Medicaid-Medicare Program where possible. RCCOs should also ensure that engagement with clients, their families, and advocates includes a diverse representation that ensures the RCCO is responsive to community needs and encourages building of a medical neighborhood to include behavioral health providers, PCMPs, and non-medical providers. The PIAC should continue to be required to meet at least quarterly, with minutes posted to the contractor's website, and RCCOs should complete PIAC projects in a reasonable time frame to promote member engagement and innovation. Members have different health beliefs, and opinions, on how they receive care. Therefore, member focus groups may continue to be useful in ensuring that RCCOs are able to adjust to varying local community and member needs specific to their unique region. RCCOs should also continue to be required to promote member education and healthy lifestyle choices in a manner that is appropriate for the respective region (newsletters, decision aids, etc.).

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

Again, the PIAC should remain as a requirement for RCCOs as the committee provides for member, provider, community, and social service provider engagement in a forum that promotes collaboration and accountability amongst the local community. Moreover, RCCOs should be required to put in place guidelines that facilitate stakeholder engagement across RCCO boundaries where appropriate. In order to promote ongoing feedback, process improvement, and innovation RCCOs should be required to regularly survey providers, community organizations, and social service providers to glean specific feedback that can be used to improve care coordination, overall engagement, and build upon comprehensive care coordination, integrated care, and a patient centered medical neighborhood. Suitable suggestions made by stakeholders should be implemented in a reasonable time frame as deemed appropriate by the RCCO. The RCCO should be able to adjust to the feedback of stakeholders in a way that allows for local variation amongst each community.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

It is crucial that RCCOs are able to respond to the unique needs of their respective communities. Much work has been done to establish and maintain relationships within local communities. In HCPF's scoring and RFP should award extra points for community involvement. It is important to create community involvement that demonstrates the responsiveness of RCCOs to their community and ensures stakeholders have a vested interest in the success of the RCCO. RCCOs should also work with their respective communities to reduce duplication of services, eliminate redundancies, and/or collaborate where

appropriate in an effort to streamline services, refer to appropriate resources, and build upon referral networks which can positively impact the medical neighborhood as well as health and well being of the member. It also may be beneficial to communicate opportunities for public comment, specific to the work of the RCCOs, with an ever-widening net to ensure the uniqueness and diversity of each community is represented. Enhanced community engagement may also be created through an annual Colorado ACC conference that provides opportunities to share best practices, successes, collaborate, and create deeper community engagement.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

The Department should continue to require that RCCOs submit a regular Stakeholder Feedback report that describes the contractor's work in collaborating with stakeholders, a summary of stakeholder feedback, trends, issues, complaints, and proposals to solve issues. The Department should allow for RCCOs to be less prescriptive in how they address issues, which allows for local variation and ensures a local patient centered approach that better meets the needs of the individual than a population specific approach. Stakeholder engagement is critical to the success the ACC. Ongoing regular consultation, involvement, and broad inclusivity of stakeholders will remain important in steering ACC initiatives, promoting shared accountability, two-way engagement, and collaborative decision making that allows for flexibility by region. Stakeholder engagement should not merely be a public exercise but a way to engage in issues that matter to the respective community, which goes beyond reporting, where information is used to make critical decisions. In that, it's important to tie stakeholder benefits to the goals of the ACC where appropriate. RCCOs should be able to demonstrate and report on their successes, as well as lessons learned, through interacting with stakeholders and be allowed to adjust programming as appropriate while ensuring the Department is well informed through a regular reporting process.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

- No, access to specialty care in rural/frontier areas is very limited.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

- Gaps are not population specific.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program? No answer submitted

b. What role should pharmacies play in the next iteration of the ACC Program? No answer submitted

c. What role should specialists play in the next iteration of the ACC Program? No answer submitted

d. What role should home health play in the next iteration of the ACC Program? No answer submitted

e. What role should hospice care play in the next iteration of the ACC Program? No answer submitted

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program? No answer submitted

g. What role should counties play in the next iteration of the ACC Program? No answer submitted

h. What role should local public health agencies play in the next iteration of the ACC Program? No answer submitted

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations, which have been overlooked in the past? No answer submitted

45) How can RCCOs help to support clients and families in making and keeping appointments?

- Outreach has worked for MHCs

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

- We would suggest allowing RCCOs to make this proposal in the RFP.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Health workers should reimbursed through individual RCCO contracts – this should not be prescribed by HCPF in the RFP

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

- Whole-person health does include the mouth. We recommend that oral health should be included in the RCCO.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

- Excellent care that values regional values, spiritual values, cultural traditions, language, and customs.

b. What RCCO requirements would ensure cultural competency?

- No answer submitted

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

- No answer submitted

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

- No answer submitted

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

- This decision should be up to each RCCO in their RFP

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

- The ACC program should develop a way for RCCOs to share more real-time data with providers so they can intervene concurrently while a patient is still receiving emergency services.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

- No answer submitted

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

We believe that the state should avoid designing a one size fits all program and instead allow regional RCCOs to design what best works locally.

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☒	☐	☐
Network provider education	☐	☒	☐	☐
Assistance with practice redesign	☐	☒	☐	☐
Assistance with efficiency-enhancing activities	☐	☒	☐	☐
Provide web-based resources and directories	☐	☒	☐	☐
Provide practice-specific data reports	☐	☒	☐	☐
Provide clinical care guidelines and best practices.	☐	☒	☐	☐
Provide clinical screening tools	☐	☒	☐	☐
Provide health and functioning questionnaires	☐	☒	☐	☐
Provide chronic care templates	☐	☒	☐	☐
Provide registries	☐	☒	☐	☐
Offer client reminders	☐	☒	☐	☐
Offer client self-management tools	☐	☒	☐	☐
Offer educational materials about specific conditions	☐	☒	☐	☐
Supply behavioral health surveys	☐	☒	☐	☐
Supply other self-screening tools	☐	☒	☐	☐
Administer behavioral health surveys	☐	☒	☐	☐
Administer other self-screening tools	☐	☒	☐	☐
Prepare client action plans	☐	☒	☐	☐
Provide training on providing culturally-competent care	☐	☒	☐	☐
Provide training to supporting staff	☐	☒	☐	☐
Provide training on motivational interviewing	☐	☒	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☒	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☒	☐	☐
Provide referral and transitions of care checklists	☐	☒	☐	☐
Provide visit agendas or templates	☐	☒	☐	☐
Provide standing pharmacy order templates	☐	☒	☐	☐
Provide comprehensive directory of community resources	☐	☒	☐	☐
Provide directory of other resources	☐	☒	☐	☐
Provide materials regarding Nurse Advice Line	☐	☒	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☒	☐	☐

Others	

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

- No answer submitted

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

- No answer submitted

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

- Rate enhancements for participation in the RCCO program as defined by the RCCO in the bid process

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

- No

58) Please share any other advice or suggestions about provider support in the ACC.

- No answer submitted

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- No. Substandard Medicaid fee-for-service provider reimbursement rates, even when combined with RCCO provider PMPM payments provide little incentive for PCMPs. Reimbursements are certainly not adequate to mature strong medical homes. We must discover more innovative ways to deliver cost effective care. Some type of shared savings will be instrumental to any solution.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

- The BHO has operated through the entirety of our contracts in an at-risk environment using a global budget. We believe this system could work equally well in the RCCO.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

- In some cases, yes. Medicaid providers serve low-income populations and some may require extra assistance in building their RCCO client-capacity. Larger providers are often more adequately staffed and trained to deliver the services critical to medical home success and consequently, a value-based reimbursement system would likely favor those entities. Some of the barriers to smaller, less mature practices include strained & less adequately-trained clinical and administrative staff, antiquated records systems, the lack of EHR's, and inability to manage expanding regulatory requirements. Inefficient processes quickly translate to higher costs and mitigate the advantage of value-based payment systems. Finally, it is important to keep in mind providers are strained with similar, but distinct care management mandates from other insurers, often adding yet another obstacle to uniform care delivery.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

- No answer submitted

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

- The RCCO's relationship with network providers and their level of participation in coordinating patient care should dictate the control of incentive distributions. And as goes provider performance, so goes RCCO performance, and both should be measured by the same standards. However, we believe RCCO's should be given the option to dictate the distribution of value-based payments to the providers within their individual regions.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- We must create more robust systems of quality measurement and evaluation of payment reform pilot programs, ones which align financial incentives and support ACO capacity-building. RCCO incentive and shared-payment capacity must be directly tied to their ability to manage population health and improve outcomes. And, to determine the most efficient care management activities needed to deliver those quality outcomes, it is imperative RCCO's have access to timely data, particularly data related which drives agreed-upon KPI's.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Capitation payment (PMPM) with rate setting factors that reward quality

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

We believe a comprehensive set of measures for client experience is critical for RCCOs success to align to their needs and remain patient-centered. RCCOs should be encouraged to weigh in on the process and suggest additional measures.

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	
SF-12 Health Survey	☒	☐	
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☒	☐	
Focus groups	☒	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

- This needs to be the responsibility of the RCCOs but must be funded by the state.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

- Open and transparent through a website

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☒
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

- It should happen in combination: overall KPIs should address population health while still addressing local needs.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

- Based on improvements

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

- No answer submitted

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

- No answer submitted

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

- The MHCs are tied to 28 quality and outcome measures but none connect to reimbursement at this point.

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☒
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☐	☒
Smartphone app	☐	☒
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☒	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☒	☐
Practice assessment tools	☐	☒
Practice management tools (scheduling, billing)	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☒
Patient education/wellness tools	☒	☐
Provider/case manager directory	☐	☒
Shared decision-making tools	☒	☐
Telemedicine software	☒	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☐	☒	☐
Health risk assessment software	☐	☐	☐	☐	☒
Practice management tools (scheduling, billing)	☐	☐	☐	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☒	☐
Patient education wellness tools	☐	☐	☐	☐	☒
Provider/case manager directory	☐	☐	☒	☐	☐
Shared decision-making tools	☐	☐	☐	☒	☐
Telemedicine	☐	☐	☐	☐	☒
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

- The primary barrier for staff is feeling comfortable with multiple platforms of technology for reimbursement.

81) How can Health Information Technology support Behavioral Health Integration?

-

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

- Yes, and it should rest in the RCCO.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

- The Connect for Health CO provider esource guide is a good model for a directory.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

- CORHIO and QHN need to function across the state. This is critical.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

- A merged physical health/behavioral health EMR
- Tracking in real time access to care data
- CORHIO/QHN implementation – this is very slow in our region

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

- More needs are necessary in frontier and rural areas for IT supports. In larger cities, larger health systems can combine efforts to scale IT needs for communication.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

- See number 86 above

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

- No answer submitted

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 055

Accepted by: KJDW

Notes: Standard cover sheet added;

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Polly Anderson for CCHN
Location: Denver, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Community Health Network
Location: Denver, Colorado
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☒ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☒ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:

The Colorado Community Health Network (CCHN) is the statewide membership association for Colorado's 18 Federally Qualified Community Health Centers (FQHCs or CHCs). CHCs provide a health care home for almost 650,000 Coloradans, including 28% of all Medicaid enrollees in 2013. CHCs have been integral to the ACC program and its success. CHCs helped launch the ACC by taking the first enrollees in 2011, formed the RCCO or serve in a governance role in several regions, serve the majority of patients now enrolled, and serve over 40% of the patients attributed to a PCMP (as of October 2014). CCHN has been an active participant in the ACC performance improvement advisory committee (PIAC) and subcommittees.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

See response above.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☒ N/A

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

As the statewide member association representing Colorado's 18 CHCs, serving 28 percent of Medicaid enrollees in 2013, and over 40 percent of the patients attributed to an ACC PMCP (as of October 2014), CCHN and our members have been highly involved and integral to the ACC program and its success. The ACC has been a positive step towards improving care coordination and establishing more accountability for outcomes, most notably:

- Financial support for care management has brought focus to high risk populations.
- Partnerships with local hospitals and community partners have been strengthened in some regions, particularly around the Key Performance Indicators (KPIs).
- Medicaid, RCCOs and PCMPs are engaging to improve outcomes and contain cost growth.
- Payment reform is being piloted and conversations are underway about how and when to include additional regions and/or providers.

2) What is not working well in the ACC Program?

While the ACC has led to some improvements in care, there are a number of areas in need of further development. To further improve the outcomes of the ACC, the following areas are in need of particular attention:

- Attribution:
    - Too many Medicaid enrollees remain unattributed to a PCMP for too long, decreasing the ability of PCMPs to engage patients and begin implementing interventions to improve outcomes and contain costs. While monthly attribution has addressed some of these concerns, the ACC program should move to auto-assignment for those that remain unattributed after attempts have been made to have them select a PCMP. See question 30 for specific recommendations about auto assignment.
    - The process to change PCMP attribution is too burdensome on the patient, and as a result some providers serve as a patient's PCMP without the recognition and financial support provided by accurate attribution. This process needs to be refined to allow patients to change PCMPs in a timely fashion.
- Timely and accurate data is central to a provider's ability to successfully manage population health and make adjustments to improve outcomes. Current data provided to PCMPs is not timely, not actionable, and not presented in a way that allows providers to validate that their data is accurately represented. Additionally, data provided varies by RCCO and therefore cannot be aggregated across regions, preventing PCMPs serving patients from multiple RCCOs to accurately understand their performance. Specific recommendations regarding data are included throughout this response, but in particular see the Program Structure and Health Information Technology sections.
- RCCO and PCMP relationships vary by region and present challenges for large PCMP systems located in multiple regions. These large PCMPs often find themselves stretched between differing requests and requirements, and varying priorities and strategies which are not always coherent. In one example, a CHC serving multiple RCCOs was able to launch a diabetes intervention program in one region with a RCCO, but not another, which resulted in participation being dictated by the county the patient lived in

even when they utilized the same clinic and saw the same provider. In addition to increased standardization of expectations across RCCOs, RCCOs need to be held to a high standard of engaging PCMPs in discussions that will impact clinical practice or reimbursement. See Program Structure section for specific recommendations.

- The ACC program should require more transparency from RCCOs in governance, operations and financing to be assured that there are adequate dollars going to impact care and provide support to providers.
- Hospitals must play a significant role in the ACC to achieve the desired outcomes of better health care and healthier patients at a lower cost, but there are not enough incentives currently to participate, nor disincentives for not participating in these efforts. Isolated, local relationships may be strong enough to create some impact in a single community, but incentives are lacking in the current ACC and should be included in the next iteration.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

Similar to the ACC, CHCs have seen both areas of success with the BHO system and areas in need of significant change. A few successes to highlight:

- Access to behavioral health care is expanding in some areas as Community Mental Health Centers (CMHCs) are hiring staff and working to meet the increased demand created by Medicaid expansion.
- Partnerships between CMHCs and CHCs are very strong in some areas, resulting in improved access to behavioral health services through the integration of CMHC staff into CHC care teams, and in a few places, improved access to primary care by bringing CHC staff to the CMHC.
- The launch of the statewide crisis response system is filling a gap and providing a service that was not available in the state before now.

4) What is not working well in the BHO system?

Overall, the focus of the BHO program on covered diagnosis and procedures does little to support integration in the primary care setting, where the behavioral health needs of patients don't always fall neatly into a diagnosis. PCMPs are ideally situated for providing preventative care and early interventions, but PCMPs must navigate complicated and varied CMHC/BHO relationships and billing procedures to receive payment for this care. Access to behavioral health care for Medicaid patients seems to be improving where there have been issues, but continues to vary by community and region and is overly dependent on local contractual relationships.

The separation of funding for behavioral health care from medical health care, does not allow for the alignment of incentives to improve care. Integrating the funds for medical and behavioral care (e.g. ending the carve-out) will make both service provision and access to care more efficient and patient centric. Money should follow the patient, meaning if a patient receives their behavioral health care at a CHC, the CHC should be able to bill a single entity for care. In addition to the need to integrate funding, the following issues need to be addressed:

- Access to psychiatric care for Medicaid patients continues to be highly limited. In particular this is true for patients with intermediate level needs, as the focus has been placed on providing care for patients

with the highest needs. Additionally, to increase access to care, the following need to be included as performance measures: wait time for an appointment, underutilization monitored by comparing disease prevalence rates to penetration rates, and network/provider experience reporting.

- The CCAR is not designed to assess and report progress on behavioral health issues that are typically addressed in the primary care setting. Further, the lengthy CCAR, in combination with other requirements to "open" a case with the BHO, is not compatible with the fast pace of the primary care setting, where increasingly behavioral health providers are utilized to assist with brief interventions in the exam room. Generally in the primary care setting, patients are "enrolled" indefinitely and may receive care across their lifespan without regard to acuity or diagnosis, and at CHCs, even as their insurance status moves from Medicaid, to uninsured or commercially insured.
- The requirement that CMHCs ensure co-location at high volume practices needs to be reviewed for compliance and enforced.
- There is no clarity or direction on the intended relationships between BHOs and RCCOs, so these relationships vary greatly depending upon the region.
- The rules and regulations of the BHO system are cumbersome in integrated care settings, providing reasons to resist creative integration opportunities. Additionally, for behavioral and medical care to become more integrated, incentives need to be aligned for both sets of providers.
- PCMPs contributing to positive care outcomes and cost avoidance on the BHO side of Medicaid have no ability to share in the savings generated.

5) What is working well with RCCO and BHO collaboration right now?

In one region the BHO and RCCO are collaborating closely to make care transitions seamless, but this is not the experience across the state. BHO and RCCO relationships appear to be limited as CHCs are not aware of much collaboration at the patient level that could impact care.

6) What is not working well with RCCO and BHO collaboration right now?

Without a specific requirement to collaborate, integration seems to be a locally driven effort, and is not being mirrored in the relationship between RCCOs and BHOs as stated in question four. Having discussions at the regional level could lead to consistency across the region and assist in extending partnerships to all providers. Without regional level leadership, access to care depends upon local relationships; this creates gaps in access to services where relationships are not strong.

Sharing of data is a barrier at the practice level, and it is unknown what, if any, data is being shared between RCCOs and BHOs. Increased partnership regarding data sharing between systems could greatly benefit clients by improving patient centered care.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Central to successful behavioral health integration is the integration of funding, as stated in question four. The RCCO rebid process should be used to begin developing alternative payment structures. Blended funding will lead to the best patient care by removing barriers to providing needed care, and it would be a good start to payment reform.

RCCO and BHO contracts should be changed to require and demonstrate partnership at the both the regional and practice levels.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	Carving out behavioral health funding creates silos which are an inherent barrier to integration.
Community Behavioral Health Services Rule	☒	☐	Rule places too much emphasis on providing high level care. To encourage preventative care and early intervention it should authorize receiving care through patient chosen providers, including PCMPs.
Covered diagnoses list	☒	☐	Too focused on severe and persistently mentally ill
Different behavioral / physical health reimbursement	☒	☐	This creates different systems of service with different outcome measures and objectives.
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	The CCAR is overly burdensome in primary care settings. The requirement to license substance abuse providers and facilities (vs. just providers as in other areas of behavioral health) creates a burden for primary care providers that could otherwise expand SA services on site.
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☒	PMPM itself is not a barrier, but the amount can be if it does not sufficiently cover expenses of required services.
Physical space constraints	☐	☒	
Privacy Laws (HIPAA, 42 CFR)	☒	☐	42 CFR in particular is a barrier, including over application/mis-application of current rules.
Professional / cultural divisions	☒	☐	CHCs providing onsite, integrated care have found that many behavioral health professionals need additional training to function in team based care models. Moving from the intensity of counseling sessions to brief interventions and opening and closing cases based on strict criteria to providing a broader range of

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

		behavioral health (vs. mental health) interventions is challenge for BH professionals new to the primary care setting.
RCCO or BHO contracts	☒	☐	See responses to questions 5-7
Staff capacity	☒	☐	CHCs face recruitment challenges for qualified staff.
State/Federal rules or reporting requirements	☒	☐	The narrow definition of behavioral health providers that are billable to a BHO create difficulty when partnership with CMHC is not possible.
Technical resources / data sharing	☒	☐	The systems are often not in place or extremely expensive to implement and maintain to share data between providers. Data sharing between RCCOs and BHOs if done, is not shared with PCMPs.
Training	☒	☐	Training on how to work as a member of an integrated team is not readily available, so integrated practices are recruiting from a narrow group of behavioral health providers who already have the needed experience.
Others			

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

The state needs to maintain consistency between the ACC expectation regarding integration and what is contained in the State Innovation Model (SIM) proposal presented to CMS. Of particular importance in the SIM proposal is the expectation that integrated care requires integrated, on-site teams of behavioral and physical health clinicians working on a unified care plan. Additionally, CCHN feels that medication management, integrated health records, and providing for the majority of a member's comprehensive primary, preventive and sick care is necessary for a practice to be integrated.

It is also worth noting, that without the inclusion of oral health care, true whole-person/whole-family care is not achieved. Across the state CHCs are demonstrating how it is possible to care for the whole person through our focus on all three elements: physical, behavioral and oral health. While not every clinic is providing all services on site, they are all committed (and federally required) to addressing the needs of their patients in a comprehensive way through service provision and community partnerships. Not only are CHCs demonstrating the possibility of comprehensive care, but the benefits: Colorado Department of Health Care Policy and Financing data shows that CHC patients have one-third few emergency room visits, hospital admissions and primary care preventable hospital admissions than private FFS providers.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Integration of funding in Medicaid for mental and physical health is required to make primary, preventative and behavioral health services more efficient and patient centered. Money should follow the patient – if a patient receives his/her mental health care at a CHC, the CHC should be able to bill HCPF directly for those services. Aligned with this and the comments made throughout this section, payment systems and contracts for behavioral and physical health must reimburse for preventative efforts. The current behavioral health payment system is designed to respond primarily to individuals with behavioral health diagnoses, as opposed to paying for early psychosocial and behavioral intervention for individuals and families with risk factors. Behavioral health prevention and health promotion efforts are critically important to cost effective, patient centered care.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

The Safety Net Medical Home Initiative (SNMHI) provides the most comprehensive definition of care management, and the National Committee for Quality Assurance (NCQA) provides the most comprehensive tool to measure the implementation of care management in a practice.

SNMHI defines the key charges of care coordination as: linking patients with community resources to facilitate referrals and respond to social service needs; integrate behavioral health and specialty care into care delivery through co-location or referral agreements; track and support patients when they obtain services outside the practice; follow-up with patients within a few days of emergency room visit or hospital discharge; and communicate test results and care plans to patients/families.

NCQA's assessment of a provider's care coordination and care transition system focus on three elements: test tracking and follow-up; referral tracking and follow up; and coordinating care transitions. The specific elements outlined in these three areas provide a comprehensive image of whether the organization providing care coordination has the procedures and mechanisms in place to provide the care as defined by SNMHI.

b. How should RCCOs prioritize who receives care coordination first?
c. How should RCCOs identify clients and families who need care coordination?
d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

As referenced throughout this section, CCHN does not recommend a prescriptive approach to care coordination as it has been the experience of our members that State requirements are often pushed down to the PCMP, often without regard for the PCMP's system of care. PCMPs and RCCOs should work together to develop systems for identifying those most in need of care coordination supports, and the value of having a local care coordination provider should always be considered in identifying if the service is best offered by the RCCO or the PCMP.

12) What services should be coordinated and are there services that should not be a part of care coordination?

No service should be explicitly excluded from care coordination, though there are several areas that require further development including:

- Pharmaceutical care coordination has primarily been focused on punitive measures that identify abuse in the system. Incorporating medication management more fully into care coordination will address those concerns while also reaching patients in need of further support with their medication.
- Communication between specialist and primary care providers needs improvement: Completing the communication loop between the PCMP and specialist is necessary to ensure that care coordinators have full information on patient needs and an up to date care plan.

- Reducing use of emergency room care for non-emergent needs continues to be a focus to reduce costs in health care, but not all regions have built systems that allow care coordinators to know when a patient has presented in the emergency room so follow up can be completed. Additionally, hospital systems tend to focus on what is needed to discharge a patient, not on connecting with providers who will continue care after discharge. Focusing on the relationship between PCMP and RCCO care coordinators and hospital systems will help address both of these issues.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

Psychosocial information such as where the patient lives, with whom the patient lives, and what resources he or she has are key to understanding what kind of care coordination he or she needs. While access to the patient's medical and behavioral health records are also essential, these often do not include the information that needs to be a part of the patient record for successful care management.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

From the experience of CHCs, two predominate models of care coordination have been identified. The first is care coordination which is disease specific. Patients with disease specific care coordination may have more than one care coordinator within the same health system. The second predominant model incorporates care coordinators into the care team, across diseases or issues. Regardless of which model is being used, it is likely that patients are engaging with other health care providers and care coordinators. To reduce duplication and improve outcomes, PCMPs need access to more complete and timely patient care data to provide meaningful care coordination across systems.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

Different organizations have coordinators dealing with different issues (i.e. housing, food access, etc.) whom may also be dealing with health care issues. The work being done by those organizations may have profound impacts on the health of a patient, but if a relationship is not present between the PCMP and the outside organization there is no way to identify those potential impact areas. To address this issue there may be a role for RCCOs in convening coordinators across communities to increase communication and reduce duplication.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

It is important to recognize that care coordination is often done by individuals with a variety of titles and training, such as Transition Coordinator, Promotoras, and Case Managers. In exploring what is already in place in a community it is important to focus on the functions and outcomes, not titles. See b. above for the possible role of RCCOs in "coordinating the coordinators."

d. What are the gaps in care coordination across the continuum of care?

PCMPs need access to real-time patient care and cost information in order to providing meaningful care coordination. Access to actionable data needs to be prioritized in the RFP.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

The areas identified in the table below are functions that the organization providing care coordination should be providing. Across the state, CHCs have care delegation agreements with RCCOs and in those situations the responsibility for coordinating with community supports and services on these issues would typically be delegated along with other responsibilities to the PCMP. In instances in which the RCCO is providing the care management (no care delegation in place, non-attributed patient, or patients attributed to PCMPs without a delegation agreement), the RCCO does have the responsibility for coordinating on each of these issues as needed within the region.

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☐	See narrative above for this table
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	
Health literacy	☐	☐	☐	
Housing	☐	☐	☐	

Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	
Transportation	☐	☐	☐	
Other				

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Care coordination models should not be dictated by the state or RCCO. Focus should be placed on the outcomes desired (see response to question 19), not on restricting or defining the providers or provider team. RCCOs and PCMPs with care coordination delegation should have the flexibility to create a system that works for their population in achieving those outcomes.

Type:	**Coordinate care?** Yes	No	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☐	☐	See narrative above for this table
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	

Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other			

17) **Care coordination requirements for specific populations**. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

RCCOs should be required to establish mechanisms for community level care decisions.

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	See narrative above for this table
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	

Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

RCCOs should connect with and complement existing resources to support children today. There should not be duplication or replacement of existing structures. This should include RCCOs connecting with regional resources and supporting PCMPs with care coordination delegated in accessing existing resources and structures for this population.

19) How should care coordination be evaluated? How should its outcomes be measured?

KPIs should continue to be used to evaluate outcomes. Additional measures that could be used are changes in the cost of total cost of care, number of emergency room visits for non-urgent issues, and patient experience and satisfaction.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

The cost of providing care coordination services varies depending on a number of factors, including volume of clients. In particular, rural areas can be more expensive because of lower volume. Budgetary constraints should not be the only consideration in setting PMPM rates, rather these amounts need to be justifiable through an actuarial process. As payment reform moves forward, transparency in what is included in delegation contracts and the justification for the PMPM amount will need to be established.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

Yes, but only if the variation in PMPM is actuarially set.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

No. Care coordination models should not be dictated by the state or RCCO. Focus should be placed on the outcomes desired (see response to question 19), not on the allowed providers or provider team requirements. RCCOs and PCMPs with care coordination delegation should have the flexibility to create a system that works for their population in achieving those outcomes.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

The Department should continue to utilize KPIs to demonstrate the effectiveness of care coordination. See response to question 19 for specific outcome measure examples.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Care coordination models should not be dictated by the state or RCCO. Focus should be placed on the outcomes desired, not on the allowed providers or provider team requirements.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Colorado's 18 CHCs have 169 sites spread throughout the state; several CHC systems span multiple RCCO regions. With some CHC systems managing relationships with up to 4 RCCOs, there are many areas where consistencies across RCCOs would improve system efficiency.

Uniform RCCO governance structure is one area that should be addressed. Suggested requirements include: consumer representation within the governance structure and seats designated for large volume providers such as CHCs; report administrative expenses transparently and be limited to a 10% administrative cost threshold (further information in Question 25).

The following functions should be standardized across RCCOs:

- PCMP reporting to RCCOs and standards for reporting needs to be standardized. It is administratively burdensome to large provider systems that serve patients in multiple RCCOs to meet varying requirements on what data and how it is provided.
- RCCO reporting to PCMPs needs to be standardized and presented in a way that allows practices providing services in multiple RCCOs to analyze their overall impact on the Medicaid population served.
    - This data should be real time to ensure care coordination and quality improvement efforts are meaningful
    - RCCOs should provide comparison data to all providers based on provider type (e.g. CHC, non-CHC, practice size, etc.)
- Referral protocols - currently the referral protocols submitted by the RCCOs vary in intensity, creating an unmanageable system of expectations for PCMPs and specialists serving patients in multiple RCCOs.
- Communication from RCCOs to PCMPs should be streamlined and RCCOs encouraged to partner in communicating to providers that serve multiple regions. In particular, attending meetings for multiple RCCOs which cover the same or similar information is administratively burdensome and unnecessary. Cross RCCO communication would allow RCCOs to identify areas in which they do not align to communicate differences to PCMPs more effectively and allow conversation regarding areas to create alignment.

Finally, as the state moves forward with payment reform, consistency will be needed in how providers are paid and large systems need to have the flexibility to choose a single RCCO with which to contract. Our response to question 26 contains further discussion of the complications of a single system managing multiple payment methodologies for a single population.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

From the provider perspective, transparency is central to being successful in establishing community relationships. Transparency should include RCCOs reporting all real and perceived conflicts of interest, reporting regularly on how state funds are being spent within the region, and including provider and consumer

representation in the decision making process. Reporting on how funds are allocated and spent by the RCCO, and capping administrative spending by the RCCO to 10 percent, would provide additional accountability and ensuring that 90 percent of funds are spent improving patient care and access to care.

In addition to expectations regarding transparency, we recommend setting the expectation for community relationships in the RFP process by requiring applicants to include letters of support from community organizations and safety-net providers and hospitals, including CHCs. To evaluate the strength of those relationships, applicants should include information on the length and extent of their relationship with those partners. Additionally, a clear plan for or explanation of their community engagement process should be included, contain what community meetings are attended and the RCCOs advisory committee structure. These processes should include a mechanism for improving community level care decisions.

Finally, to ensure that a RCCO successfully engages the communities in their region requires clear contract oversight and enforcement.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

CCHN thinks large PCMPS with sites in multiple regions should be able to select a single RCCO. The Department has stated that simplicity is one of the pillars of the ACC, and the ability to select a single RCCO decreases complexity both for CHCs and the state. As discussed in earlier questions, working with multiple RCCOs creates administrative complexities and presents barriers to future innovations to improve patient centered care, particularly around payment reform.

RCCOs themselves are very diverse organizations with different approaches to payment reform, referral processes, care coordination, and willingness to partner on innovative approaches to care. When working with multiple RCCOs, PCMPs are faced with challenges as simple as the time commitment required to attend multiple meetings on similar topics, to the difficulties of aligning systems with multiple systems, including billing systems should the RCCOs become a payer. Being able to work with a single RCCO would eliminate the complexities and allow large provider systems to work more closely with that RCCO to identify areas for improvement and innovation.

In addition to the efficiencies created, the ability to work with a single RCCO is a requirement for CHCs to pilot payment reform. A Medicaid payment pilot would have to involve all or most Medicaid patients in a single CHC system to be successful.

CCHN recognizes that this is a departure from the way the program is currently structured and there are several considerations that will need to be discussed. One of the original principles of the regional distribution was the equitable distribution of lives, so the issue to consider now is if with the increased number of patients covered whether equitable distribution is still necessary to the success of the program. A second area to consider is attribution. There would need to be a mechanism in place to ensure that RCCOs attribute to providers within their region, even if they are not the CHC-designated RCCO the provider is working with. Additionally, attribution to RCCOs is currently done based on the patient, so the criteria for how large provider systems would be attributed to a RCCO have not been established.

CCHN is interested in continuing this conversation with the Department and ensuring that the implications for either the decision to maintain status quo or allow this change are understood by all impacted. We believe there are options to address each of the concerns that would lead to an equitable solution that will be beneficial to RCCOs, PCMPs and patients.

If this change is not determined to be feasible, CCHN would ask that the Department work directly with CHCs to pilot CHC payment reform, and work with the CHCs/CCHN and the RCCOs to determine how and whether RCCOs would be involved.

27) Should the RCCO region maps change? Why or why not? If so, how?

Regions should reflect the natural referral patterns and clinical appropriateness rather than administrative simplicity concerns. As an example, Larimer and Weld counties have a lot of overlap between providers, hospital systems, and referral patterns between Loveland, Greeley and Fort Collins, yet are divided between RCCOs. These divisions may not have an impact on referral patterns or access to care currently, but as RCCOs develop medical neighborhoods they could increasingly become an issue.

In addition to the example above regarding community referral patterns, the division of natural communities, such as metro areas, creates difficulties in establishing community relationships and partnerships. For example, the Denver metro area is divided between three RCCO regions. Two of those regions share an administrative organization, but with the patient population served by Medicaid it is a recurring issue that patients move, and in doing so change RCCOs which creates communication issues.

CCHN believes that the RCCO region map should be evaluated based on the concerns of providers in those regions. Therefore, we are not making specific recommendations regarding changes, but have asked CHCs to submit comments regarding the challenges and strengths of the region(s) they serve.

28) Should the BHO region maps change? Why or why not? If so, how?

Behavioral and physical health cannot be fully integrated until payment systems are integrated, so alignment of regions is a logical first step to integration of care.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

The required time for successful transition will largely depend on the structure of the new vendor. If the vendor selected is currently serving as a RCCO in a different region, the transition should take less than three months as attention can focus on changes to contracts with providers and care coordination delegation. If the organization is a new RCCO contractor without systems in place, it will take at least six months to establish both IT systems and the contracts with providers and care coordination organizations.

In either scenario, CCHN feels that the following requirements should be established:

- There is no disruption in payment to providers,
- There is no reattribution of patients to PCMPs, and
- A measurement of a successful transition should be provider feedback.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

In order for patient designated attribution to work better, Health*Colorodo*'s contract should include the following:

- Funding and accountability to assure efficient and accurate patient designated attribution.
- The ability for clients to designated their PCMP on the Medicaid application, both on paper and through PEAK.
- Ability for all Medicaid clients, new and those previously enrolled, to submit PCMP selection and changes through a fax or online form which receives a confirmation receipt for both the patient and selected PCMP.
- Appropriate call center staffing levels to minimize wait times to under 5 minutes and a system implemented which allows patients to leave a number and be called back by a representative rather than remaining on hold.
- If a patient does not select a PCMP after a designated time period, auto attribution to a narrow group of high volume, high quality providers is implemented. Screening criteria for eligible providers should include items such as: practice open to new Medicaid patients, practices with delegated care coordination agreements with the RCCO, practices with national Patient Centered Medical Home recognition or other similar standards, practices with electronic medical records capable of running reports for patient population health management and quality improvement, and practices contracted with CORHIO.

In addition to the changes to the Health*Colorodo* contract regarding attribution, HCPF should implement policy in which providers that can demonstrate having served as the PCMP between enrollment and attribution receive retroactive PMPM payment.

The following waivers or SPAs should be sought from CMS:

- Waiver to allow patient assignment or lock in to providers. This will be necessary to move forward with payment reform because providers cannot be held responsible for managing patient health outcomes if the patient does not have an obligation to utilize the assigned provider.
- SPA to utilize projected annual income for Medicaid determination.
- Waiver to allow 12 months continuous eligibility for adults in order to address issues of churn.
- SPA for alternative payment mechanism for CHC payment once the methodology is developed and agreed to.

Suggested changes to the RCCO contracts have been outlined in Questions 24 and 25.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

The two primary limitations that need changes are regarding the cap on dental services for adults and case management restrictions.

- The need for dental care exceeds the $1,000 cap and is limiting the ability of providers to provide high quality care in an efficient time frame in order to reduce further cost implications in the future. If patients cannot afford to continue treatment after the cap the state risks those needs elevating from a simple dental procedure to an emergency room case.
- Case management is not included in the benefit structure, though it is provided by CHCs and reduces the overall cost of care. Adding case management to covered benefits would allow expansion of the service, ultimately decreasing the overall cost of caring for the population.

Additionally, the current benefit structure does not incentivize patients to utilize less expensive, more appropriate care settings. A lot can be accomplished through providers and care coordinators, but structuring the benefit to further incentivize patient choice would further these efforts.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

No, CHCs have already experienced the complications of working with multiple RCCOs and expanding the number per region would only accentuate the problem. Additionally, multiple RCCOs per region adds a degree of complexity to not only the provider level, but processes such as attribution.

While multiple RCCOs in an individual region should not be an option, there should be the ability for providers, such as CHCs, within a RCCO to partner and be acknowledged as a separate provider group or type within the RCCO. This would be beneficial in providing a mechanism for practices to track impacts and savings on a more localized level.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

All CHCs are Medicaid providers.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

RCCOs should be responsible for ensuring that everyone selects a PCMP within the first three months of enrollment. As enforcement of this responsibility, RCCOs should lose PMPM entirely for those who remain unattributed after three months.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

The Department of Public Health and Environment (CDPHE) already tracks many population level health trends which would be of use to the ACC Program. Likewise, information gathered regarding the Medicaid population through the ACC would be beneficial to CDPHE in expanding their data set. Additionally, CDPHE tracks data regarding emerging public health issues which would be beneficial to share in a timely fashion with providers, and providers could be a useful resource to CDPHE in responding to emergency situations. Collaboration around bi-directional data sharing should be built for the benefit of both programs.

Perhaps even more impactful is the relationships at the local level. RCCOs should have a requirement to collaborate with Local Public Health Departments.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

The ACC and DHS should, at a minimum, compare goals to ensure alignment. This would be accomplished best at the Governor's Cabinet level.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

The two programs should align eligibility determination methodology. For example, the two should align income requirements to annual income projections, and Medicaid adults should receive 12 months continuous eligibility. Aligning these two elements will reduce churn between the programs and increase consistency of care for patients.

Until the necessary alignments can be accomplished, Connect for Health Colorado and the ACC Program should work closely to ensure that patients whose eligibility changes and movement between the programs is necessary have consistent access to primary care.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

The ACC Program should collaborate with DOI to utilization of the Medicaid definition of Essential Community Providers is consistent with the definition in the private insurance market to ensure consistent access to ECP providers in both public and private insurance settings. Additionally, the DOI should be an active participant in payment reform discussions and evaluation of models which include risk.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

As referenced in response to question 24, RCCOs should have a uniform governance structure which requires at least two consumer representatives. These representatives should be clients, client family members or client advocates.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

As referenced in response to question 24, RCCOs should have a uniform governance structure which requires representation from providers, community organizations and others in the region.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

See response to question 40.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

The Department should continue to host one to two regional stakeholders meetings per year like those hosted spring, 2014 which were well attended. It is important that HCPF leadership and ACC staffs have a presence in each region at least once per year.

ACC PIAC and subcommittee meeting materials should be posted at least two business days in advance of meetings. Agendas for these meetings should have items for public input clearly articulated so stakeholders can come prepared to meetings to share their input.

Finally, to encourage and ensure stakeholder engagement, the Department must have technology that allows stakeholders outside of the Denver metro area to actively participate in meetings. Current call-in systems do not support active participation.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?
    a. If no, what are the gaps?
    b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

The increased enrollment in Medicaid has exacerbated the issue of obtaining timely access to behavioral health treatment and therapy, dental care and specialist care. CHC dental programs are overwhelmed with the pent up need among both those previously enrolled in Medicaid and the expansion population. Additionally, the expansion of Medicaid has made waiting lists for specialty care longer, which is particularly true in rural areas.

A large part of the problem with accessing care is the lack of providers accepting Medicaid, and part of that is driving by the lack of incentives for hospitals and specialists to engage patients and respond to the population needs. RCCOs should have the flexibility and the charge to work with providers in their regions to develop these incentives.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

    a. What role should hospitals play in the next iteration of the ACC Program?

One of the central roles that hospitals need to play is engaging with the RCCO to remove roadblocks to sharing information with PCMPs. Having access to real-time data about patient access of services in a hospital setting is essential to care coordination and engaging patients to utilizing PCMP services before an issue requires emergency care. RCCOs should develop plans to incentivize hospitals to engage in this work, to engage patients beyond just providing emergency care, and mechanisms to dis-incentivize not participating.

    b. What role should pharmacies play in the next iteration of the ACC Program?

Pharmacists should have increased representation at RCCO/regional meetings. As mentioned in response to question 12, pharmacy is an area that needs to be increased in care coordination work. Pharmacists can be contributing to care coordination through medicine reconciliation for patients and working with care coordinators to educate patients.

    c. What role should specialists play in the next iteration of the ACC Program?

RCCOs should be required to create a care transition system that includes specialists, hospitals, pharmacies, home health, hospice and PCMPs.

d. What role should home health play in the next iteration of the ACC Program?

RCCOs should be required to create a care transition system that includes specialists, hospitals, pharmacies, home health, hospice and PCMPs.

e. What role should hospice care play in the next iteration of the ACC Program?

RCCOs should be required to create a care transition system that includes specialists, hospitals, pharmacies, home health, hospice and PCMPs.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

RCCOs should have community advisory boards which include representation from SEPs, CCBs, counties, local public health agencies, and other community health organizations and nonprofits.

g. What role should counties play in the next iteration of the ACC Program?

RCCOs should have community advisory boards which include representation from SEPs, CCBs, counties, local public health agencies, and other community organizations and nonprofits.

h. What role should local public health agencies play in the next iteration of the ACC Program?

RCCOs should have community advisory boards which include representation from SEPs, CCBs, counties, local public health agencies, and other community organizations and nonprofits.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

Provider associations, including CCHN, and organizations that provide care coordination and management services should be included at the ACC and RCCO levels.

45) How can RCCOs help to support clients and families in making and keeping appointments?

RCCOs should utilize client no show rates to identify those patients potentially in need of care management and use their care management teams to find and address their root problems. RCCOs should work with their delegated practices on how to partner around no shows. Additionally, RCCOs could support PCMPs in

implementing practice level interventions, such as implementing recall or appointment reminder systems, through technical and financial support.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

The functions described should be included in each region's care coordination approach, but the specifics of job titles and the mix of providers should not be prescriptive. Community Health Workers are most effective at the PCMP level within the community, so it should be an option for PCMPs and organizations with care coordination delegation but it should not be a requirement. The focus should be on developing locally appropriate systems that fulfil the functions and meet identified outcomes.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

All options could be viable options for reimbursing for the work done by Community Health Workers, but see question 46 for thoughts on the appropriate level for utilizing these workers.

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☒
On staff (salary) at RCCO	☒
Per Member Per Month Payment	☒

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

The dental ASO's contract contains the responsibility for ensuring an adequate network of providers, so this should not be a focus of the RCCO. However, as the RCCOs are more locally focused and have established relationships in the community, they would be a good partner for the ASO to utilize in establishing those local relationships and identifying providers.

RCCO care coordinators should include oral health and accessing dental services in their efforts to get patients appropriate and timely care. To accomplish this, the RCCO should have established relationships with the

appropriate ASO staff. Additionally, RCCOs should be providing encouragement and education to patients about the importance of regular, preventative oral health care.

The CHC model of care integrates physical, behavioral, and oral health care in a patient centered setting. Throughout this RFI there is significant focus on the first two components, but little on oral health. As RCCOs provide support and trainings to practices regarding integrated care, they should be highlighting the importance of oral health in whole-person care, total cost of care and quality improvement. Additionally, RCCOs should be educating providers on options for including oral health in medical practices, including independent practice dental hygienists as an option in Colorado.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

The National Committee for Quality Assurance define cultural competency as not only having empathy, but expressing it towards patients regardless of the patient or provider's cultural background. In order to do so, clinical and non-clinical staff must have an adequate understanding of their patient population including its diversity, health literacy, language needs, etc. With understanding of the patient population, providers are encouraged to utilize motivational interviewing as a technique to facilitate culturally competent conversations.

b. What RCCO requirements would ensure cultural competency?

All clinical staff should be trained in motivational interviewing and enroll in cultural competency trainings with continual follow up, both of which RCCOs can provide or facilitate connections to. RCCOs should also require practices to determine cultural competency standards and hold them accountable for meeting training all staff about and meeting those standards.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all clients/families including those with low health literacy?

See response to b.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Bilingual or translation services, on-site staff with expertise in cultural competency, and ensuring that every patient completes a health literacy assessment are factors that contribute to enhanced cultural competency.

Skills learned during trainings would incorporate the ability to refrain from making assumptions and would ideally educate participants on what it means to have implicit and explicit biases.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

Preferred networks help manage population health and generally help reduce waste in the continuum of care, but without movement towards payment reform RCCOs will not have the ability to develop or enforce these networks.

If payment reform options with any element of risk, even if only partial, are to be considered in the next RFP, networks of preferred specialist, facility and ancillary providers must be allowed. The development of these networks will need to be coupled with enhanced prior authorization processes to allow RCCOs and PCMPs to reduce total costs, improve outcomes and improve patient care.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

At the patient level the ACC should evaluate options for slight changes to patient co-pays which would disincentive inappropriate use of emergency rooms, particularly where other care options are available. Additionally, not all hospitals are actively participating in ACC. A combined effort by RCCOs and the state should build additional mechanisms into the ACC which will engage more hospitals.

At the regional level, RCCOs should be developing community diversion strategies where one is not in place. Partnerships between PCMPs and hospitals have been highly successful in redirecting patients to primary care when more appropriate and making that care available, and RCCOs could be bringing community partners to the table to begin these discussions. Additionally, RCCOs have access to data which would allow them to analyze emergency room practices to identify outliers. Understanding if there are emergency rooms that cost significantly more than others in the region or extensive use of tests without clinical reasons would identify opportunities to reduce unnecessary care.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

The specialist network for Medicaid patients is highly limited. RCCOs need to have the authority and charge to develop incentives to encourage specialist and hospital participation.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

A high functioning RCCO should be able to provide all of these supports as needed to practices, though it should be recognized that not all practices will need these supports and therefore none should be tied to a specific tool. As PCMPs who have care management delegated, our members have most of these elements in place, and requiring a specific tool would require additional administrative work to utilize both the PCMPs process and the RCCOs, and would likely require financial investments to incorporate a duplicative function.

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☒	☐	☐	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☒	☐	☐	☐
Provide registries	☒	☐	☐	☐
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☒	☐	☐	☐
Supply behavioral health surveys	☒	☐	☐	☐
Supply other self-screening tools	☒	☐	☐	☐
Administer behavioral health surveys	☒	☐	☐	☐
Administer other self-screening tools	☒	☐	☐	☐
Prepare client action plans	☒	☐	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☒	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☒	☐	☐	☐
Provide standing pharmacy order templates	☒	☐	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☐

Provide directory of other resources	☒	☐	☐	☐
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

No specific tool should be required. Smaller practices and those without care delegation may need higher levels of support or templates to use, but practices that have care management delegation and existing processes in place should not have to change or duplicate work and financial investments to meet a RCCO specific requirement. In particular for situations in which providers serve patients from multiple RCCOs, requirements of specific tools would create additional barriers to providing patient focused and cost effective care.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

RCCOs should provide resources and support as requested by practices, but they should not be prescriptive. Especially practices that are already engaged in medical home efforts, such as CHCs engaged in Patient Centered Medical Home certification, should be able to evaluate their practice's needs and drive the support needed from the RCCO in addressing those areas. In order to accommodate both practices such as CHCs that are actively engaged in advancing the medical home model and those practices which are newer, RCCOs could consider a grant program that would allow practices to propose changes and needed supports from the RCCO.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

Established national standards, such as the National Committee for Quality Assurance's Patient-Centered Medical Home Recognition, are the most effective way to recognize a PCMP's capacity to service as a medical home for patients. These standards set expectations of what is expected of a medical home that are consistent regardless of the region and have an established process for recognition.

Practices should be compensated for their level of recognition through these national standards, with practices incentivized to improve their rate because it is tied to increased PMPM or capitation payments.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

All PCMPs should utilize a registry or electronic medical record that has the capability of running reports for population health management and quality improvement as that is the standard of care. This should be a requirement for practices to be eligible for auto-attribution as discussed in response to question 30.

58) Please share any other advice or suggestions about provider support in the ACC.

High performing PCMPs need to be rewarded based on their performance. Currently in the ACC recognition is primarily at a regional level, which does not encourage further development of those high performing practices. RCCOs should be required to report and reward individual practices.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

No, the current payment structure is still paying for volume, not quality. As discussed in response to question 58, providers are not being rewarded or tracked by their own individual performance which is not providing incentives to low performers to improve or for high performers to continue to develop. Additionally, as discussed in response to questions 4, 43, and 52 there is no incentive for specialists to participate and engage with patients in a meaningful way.

The Shared Savings component of the ACC is particular limited in its ability to recognize and reward high performers – many measures can only be attributed to the region, which may result in a high performer being left out of payments due to poor performance by providers elsewhere in the region. The size and geographic diversity of many of the regions prevent meaningful coordination and care improvements between providers, and it must be recognized that in most cases, these providers never agreed to work together or to be at risk for another provider's performance.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

CHCs are interested in working with HCPF to develop and pilot an Alternative Payment Methodology (APM) that moves away from FFS and towards population-based payment. Many CHCs are interested in taking on additional risk over time. Other states are piloting converting the PPS rate into a PMPM for primary care.

In a capitated payment structure, the initial PCMP cap should include physician services, non-E&M PCP services, and OP Labs/Pathology as these are services primarily handled by PCMPs. In later years the program could begin to expand into additional services, such as diagnostic imaging, PT/OT/ST, DME (with agreed upon carve outs), and OP Radiology (professional services only). Ideally all three elements of integrated, whole person care (physical, behavioral, and oral health) would be included.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

CHCs as providers do have the infrastructure to support value based payments, however additional resources would be needed to add expertise at the State and RCCO level for rate setting. Without rate setting expertise and third party validation, CHCs cannot risk PPS/APM and expect to remain viable.

One of the other large barriers to managing a population successfully and being paid based on value is the lack of real time, meaningful data as has been mentioned in response to questions 2, 6, 8, 14, 24, and 44. Helping to facilitate real-time data sharing between PCMPs, facilities, specialists, and community providers must be a requirement of RCCOs in order for value based payments to be accomplished.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

For providers, the need to obtain licensure will be prohibitive to participation in a model involving risk. There are models utilized, both partial risk and capitation, which do not require a DOI license if sufficient reserves are held. The Department should evaluate options for payment reform models which will not require DOI licensure.

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

For CHCs, it may make sense for the state to remain the payer to resolve the potential of large CHC systems being subject to different payment pilots or methodologies in each region where they have patients. This could also be resolved by allowing CHCs to choose a single RCCO. Regardless of the direction taken, all parties involved (CHCs, RCCOs and the state) will need to work together closely to determine the appropriate role of the RCCO in payment distribution. See also the response to question 25, 50, 68 and 75.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

As discussed in response to questions 58 and 59, high performing PCMPs are not currently incentivized to continue to improve their practice, a concern that payment reform needs to take into account. Providers who are responsible for care improvement and cost savings should be rewarded with shared savings and incentive payments.

The vision of RCCOs is to increase system effectiveness, but the care and decisions made regarding payment and practice reform most greatly impact the PCMP. To address this negotiations regarding payment reform need to be with the PCMP providers with RCCOs as a partner.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

Measurements such as clinical data on behavioral health, oral health, chronic and acute care services, unhealthy behavior, and factors that contribute to care such as social determinants of health and assessment of health literacy should be used to measure impact.

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	In 2012, CCHN worked with our members to establish patient satisfaction measures that would meet the NCQA PCMH requirements. The full CAHPS survey is composed of S2 questions and the administration of it in entirety was felt to be too administratively difficult to implement. CHCs did agree to utilize and report on S questions from CAHPS, and we would advocate considering this shortened version to evaluate patient satisfaction: 1. In the last 12 months, how many days did you usually have to wait for an appointment when you needed care right away? (a. Same day, b. 1 day, c. 2 to 3 days, d. 4 to 7 days, e. More than 7 days) 2. In the last 12 months, how often did this provider explain things in a way that was easy to understand? (a. Never, b. Sometimes, c. Usually, d. Always) 3. In the last 12 months, did anyone in this provider's office talk with you about specific goals for your health? (a. Yes, b. No) 4. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 12 months, did you see a specialist for a particular health problem? (a. Yes, b. No – if no, skip question S) S. In the last 12 months, how often did your provider seem informed and up-to-date about the care you got from specialists? (a. Never, b. Sometimes, c. Usually, d. Always)
SF-12 Health Survey	☒	☐	This tool is not used by CHCs at this time, so while we have no objection to it being an option, it should not be the only tool available.
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☐	☒	The tool is not used for patient satisfaction, primarily a patient education tool
Focus groups	☒	☐	
Other	The state should focus on patient satisfaction tools, not patient education tools. Additionally, as referenced in other questions, tools should not be prescriptive and requiring practices to implement duplicative efforts.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

The Department should look beyond claims data to other partnerships that could be provided to develop data on population health, in particular through partnership with the Colorado Department of Public Health and Environment (CDPHE). Claims data, lab and pharmacy data, CDPHE's health survey data, and outside data sources such as the Colorado Health Access Survey could be utilized to measure population health until more robust and timely data tracking and measurement tools are in place.

In developing ways to measure population health the Department should not develop prescriptive tools for implementation in PCMPs, but should look for ways to mine data from what is already tracked by PCMPs.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

PCMPs should be included in the development of reporting models in order to ensure transparency in how their data is utilized and that reports are presented in a way that can be utilized to facilitate further improvements in their system. To address these concerns, a review system should be established to create and maintain transparency and integrity of data, and large PCMP systems, such as CHCs, should have representation in that system.

Quality and performance data should be reported to PCMPs consistently across RCCOs so that those who serve patients across multiple regions can better understand their impact on their patient population. Additionally, this data should be provided on a regular basis and should include comparison information demonstrating not only how the PCMP is performing in relation to itself, but also in relation to comparable practices and the region as a whole. Presenting comparison data is the only way to identify top performers and ways to learn from their system to achieve the triple aim.

69) **Measures for payment**. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

The problem has been the frequency with which the Department has changed measures. Impact cannot be measured over time if the measures do not remain consistent. Over time it would be feasible to add additional measures, but at the moment the Department needs to identify a set of core measures that will be maintained.

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☒
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

The percentage should start low and be increased over the period of the contract as policies and reporting systems need to be established in order to tie payment to performance. As referenced in response to questions 61 through 63, CHCs are interested in the development of models with capitation and risk corridors, but in developing those models we are opposed to a fixed formula regarding the percentage of payment tied to performance. The question should be regarding how to accelerate payment to high performing RCCOs.

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Yes, all regions should have the same KPIs, and RCCOs and providers should be working toward the same statewide goals. This is necessary because to achieve KPI performance large PCMP systems, such as CHCs, adopt organization wide quality initiatives which will impact sites across multiple RCCO regions.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Reimbursement should be based on progress toward meeting national standards, with ongoing rewards for those who meet or beat the standards. While it might be necessary to create incentives that are based on individual improvement to encourage movement towards national standards, payment systems should more heavily reward those that have meet and continue to beat national standards.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

Yes

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

Increased transparency, as discussed in response to questions 2, 24, 25 and 63, is necessary to strengthen relationships with RCCOs as it is not clear that funding is being sufficiently invested in care and the care system. To address this, RCCO's should have a ten percent administrative cost threshold. Additionally, a medical loss ratio standard should be established and RCCOs should have reporting requirements regarding funds spent and unspent.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

CHCs monitor and report performance publicly via the Uniform Data System and small amounts of funding are increasingly tied to quality payments, including:

- Performance in Medicare Advantage
- Meaningful Use has paid practices based on meeting quality outcomes with HIT PCMH attainment

CHCs are increasingly seeking and occasionally receiving reimbursement for performance on patient satisfaction, provider satisfaction, services and screening rates, and access and availability measures.

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other: As providers, CHCs find phone calls and face-to-face meetings to have the most success in communicating with patients. Some CHCs have begun to use text messages and all are working to get patients to use web portals. Meaningful Use requires the use of patient portals, but it is too early to know at this time if this will work with the population served.		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Responses in the table below reflect what the majority of CHCs in Colorado have. Individual CHCs have been encouraged to respond with their specifics.

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☒	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☒	☐
Practice assessment tools	☒	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☒	☐
Shared decision-making tools	☒	☐
Telemedicine software	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☐	☐	☒
Health risk assessment software	☐	☐	☐	☐	☒
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☒	☐	☐
Patient education wellness tools	☐	☐	☐	☐	☒
Provider/case manager directory	☐	☐	☒	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☒
Telemedicine	☐	☐	☒	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

The lack of access to timely, updated and accurate information regarding care sought outside of a CHCs system are needed to be actionable for care transitions and planned care. The lack of shared data systems is a huge barrier to this, but CORHIO is a quickly developing solution to this issue that should be utilized and encouraged.

The issue is the inability to share data across systems, not necessarily the systems themselves. Consequently, requirements from RCCOs to implement specific systems that don't align with a practice's existing system will not address the issue and will only create need for additional administration resources. RCCOs should work with their providers and CORHIO to address these issues.

81) How can Health Information Technology support Behavioral Health Integration?

The issue with technology and the integration of physical and behavioral health is not in relation to the capabilities of technology. As mentioned in response to question 80, CORHIO has been able to develop

mechanisms to bridge gaps between different systems in order to facilitate access to real time data. However, CORHIO has not been able to address the barriers related to sharing behavioral health information as the federal regulatory requirements on sharing this information are more burdensome. Changes are needed to the regulations that are preventing data sharing from behavioral health.

Without changes to regulation, integrating and sharing data between behavioral and physical health can only be done on an individual partnership level and will continue to require highly sophisticated systems. Until regulations can be changed, RCCOs sould be supporting local efforts to develop these systems.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

Yes, there needs to be a way to share data across systems in the next iteration of the ACC because without it there is no way to ensure that PCMPs across the state are getting consistent data, which is of particular concern for those participating in multiple RCCOs. As discussed throughout this response, this shared data and analytics platform should not create additional administrative burdens and costs for PCMPs, but should utilize available technology to share data across systems. In order for it to be useful, it must also meet basic requirements of transparency and timeliness:

- Transparency would be established by ensuring the ability to see background data being compiled and a vendor that is responsive to questions.
- Real time information about care accessed is necessary to provide timely, actionable data for care coordinators the information needed to address high utilizers now.

While individual care data is useful in care coordination, a shared data and analytics system should also be able to run useful reports on the population they serve as a whole. These reports should include outcome data and true cost of care comparisons rather than just percentage change information. Additionally, for PCMPs to control the cost of care they need information about the charges associated with care provided outside of their system. The data and analytics tool should allow providers to see if a hospital or specialist cost is significantly higher than another to enable the provider to make a smart referral.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

No. Refer to response to question 80 regarding the issue to address being the ability to share information across systems, not implementation of duplicative systems at the practice level.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

No. Refer to response to question 80 regarding the issue to address being the ability to share information across systems, not implementation of duplicative systems at the practice level.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

A provider directory should be searchable by provider, site, and/or entity; contain information on if they are currently accepting new ACC enrollees; and contain accessibility information such as hours of operation and languages spoken. Additionally, the provider interface should have a way to easily update information, contain provider contact information, and contain information regarding making referrals to the practice. On the patient side it should also contain quality information about the provider.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

As stated throughout this response, access to actionable, real-time data needs to be prioritized by the Department. PCMPs need access to more complete patient care and cost data, often across RCCOs, to effectively manage the population and provide care coordination.

In addition to the comments made in response to question 82, RCCOs should be working with providers, including PCMPs, hospitals and specialists, across their region regarding how data will be shared. These conversations should happen within a state wide context as often patients and providers cross RCCO region lines. RCCOs could both be supportive of efforts to join CORHIO to achieve the outcome of sharing actionable and timely clinical data, and be implementing requirements that providers engage in these efforts.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

There are many HIT solutions which would provide benefits to clients, providers and RCCOs. Patient access to web portals to track their health information and direct messaging with providers would be useful in engaging patient in their health. Telemedicine, especially in relation to accessing specialists, would beneficial in expanding access to care. Instant communication in the form of email or text when a patient presents in the ER would be beneficial to case managers.

In order for any of these to be utilized to the full extent of their possibilities, there needs to be a system in place for sharing data across systems. CORHIO is a locally developed solution that could be wider used to address this barrier.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

RCCOs should be encouraging or requiring participation in CORHIO and including technical assistance with that process, which would address a requirement that they should have to ensure the flow of information across systems. Additionally, RCCOs should be providing support to Meaningful Use implementation, which could be simply coordinating with organizations that provide support in this area

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

As mentioned throughout the answers to questions in this section, CORHIO has a large role to play in successfully developing the data systems which will allow real-time, clinical data to be shared, which is required to fully realize the benefits of care coordination. Many of the barriers that were alluded to in the questions of this RFI, such as is a single system needed for a particular purpose across a region, are issues CORHIO has already been working on solutions to, so they should be included as a partner in these efforts from the beginning.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

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Accepted by: KJDW

Notes: Standard cover sheet added;

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: R Holbrook Stapp

Location: 9094 E Mineral Ave

Suite 120

Centennial, CO 80112

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Pediatrics S280

Location:

☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty:
  ii. Area of practice: Pediatrics
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Medicaid providing private pediatric practice

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Medicaid providing private pediatric practice

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☒ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Are you currently involved in the ACC program?

☐ Yes

Concerned about metrics, data integrity, analysis and how they will be used to modify payments to providers.

☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☒ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.

- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.
    - So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
    - Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
    - There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing SOAC data is just one way to understand the activities within a medical home. SDAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients
  b. Telephone consultation by a child psychiatrist to primary care providers
  We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Care Coordination

Question 12) What needs for children/families should be coordinated in medical homes and are there services that should not be a part of care coordination by the pediatric and family medical home

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Our medical home relates to multiple RCCOs and we want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we could receive a pmpm from all of

them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where should care coordination be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill? The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County
- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to

develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

- Since children are the majority and give the best chance of truly improving health and wellness, KPIs need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully. Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to

capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and provider from medical homes to develop a vetting process that will enable HCPF and RCCOs to trust medical home self-reported real-time data.

- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd.
  Appropriate child health measures could be selected from the following measures :
  - Well child visits appropriate for age
  - Developmental screening by three years of age
  - Teen depression screening
  - Complete immunization status by age two
  - Post-partum depression screening rate for mothers of newborns by age 4 months

- Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
  - Patient (or family) satisfaction ratings
  - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of
Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 057

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

ACC Request for Information

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Fernando A Martinez, CEO

Location: Alamosa, Alamosa County, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: San Luis Valley Behavioral Health Group

Location: Alamosa, Alamosa County, CO

X Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
X **other provider**
  i. **Type or specialty: Behavioral Health**
  ii. **Area of practice: MH and SUD**
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe):

Are you currently involved in the ACC program?

X Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
X 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs: We are a member of a BHO. We have worked very closely with ICHP and provide care coordination services for our area.

Please briefly describe your involvement with Medicaid, either in Colorado or another state: We serve the behavioral health needs of the Medicaid population in the 6 counties of the San Luis Valley.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

X Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

The RCCOs try to collaborate at the local level. This is a major strength of the program. It will be helpful to have the RCCOs continue to work on local solutions, but to collaborate at the higher level to share solutions, and determine if they fit in other areas of the state. It is important to continue to allow the solutions to be driven locally between the RCCO and the communities.

2) What is not working well in the ACC Program?

Payment reforms are not keeping up with the needs in the community. It is imperative that payment models allow for the flexibility to serve all community members. It will be necessary to create payment structures based on outcomes in the communities and allow for population based health outcomes for the region that is supported by the RCCO. A risk-based payment model with outcome requirements may be a solution to this challenge.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

The BHOs have shown that they are able to provide services to many people with complex needs and support their continued recovery. The current risk-based payment structure has allowed the BHOs to meet the needs of the population they serve and cut the costs for serving those clients. It is the belief of this organization that we must have a risk-based system in the future of our RCCOs in order to achieve the triple aim.

4) What is not working well in the BHO system?

The system needs to be focused on outcome based reimbursement for the services provided to members. Not only will this require an agreement on which outcomes should be measured and how, it will also require data system streamlining and reorganization. It will also be necessary for the BHOs to have access to physical health data in "real-time" in order to assist in driving down those costs for members who have dual diagnosed conditions in chronic physical health and behavioral health.

Colorado is also experiencing a shortage of qualified professionals to serve the population and meet the coding requirements that are currently in place. It will be necessary to acknowledge this shortage and be able to provide higher incentives and quicker license transferability so providers can recruit from the national pool.

5) What is working well with RCCO and BHO collaboration right now?

The collaboration and team approach with the RCCO ensures that medical management and care coordination are provided in a comprehensive framework, including utilization of health data, assessment, and holistic care planning that supports the patient/family-centered approach, and that services be integrated comprehensively.

Again, the collaboration between the RCCOs and the BHOs has been most successful because of the allowance of local solutions to local issues. This must be considered as the new bid is written. The collaboration has also allowed for conversations to be had about system and organizational barriers to providing care for the members. These solution-based conversations and plans are the key to providing excellent service to our members and reaching the triple aim.

6) What is not working well with RCCO and BHO collaboration right now?

Data that is essential to outreach and care coordination is not shared, and the data we do receive is 90 days or more outdated.

In addition to receiving the data in a more timely fashion, we need to be able to share data in a transparent way to our members. There is some confusion from members about why and how we (the BHO) know about their care coordination needs.

While conversations are starting about the barriers in all of our systems, there seems to be a scarcity mentality around the payments and that there needs to be a "competition" to survive and provide all services in one place instead of focusing on partnerships and mutual accountability. It will be necessary for the new RCCO plan to address payment concerns and partnership accountability adequately. There is still a need for specialty care and specialty services, the important part is to coordinate and work together to reduce the duplication in services in order to provide a smooth pathway to a healthier life for the members.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

It is important to realize that integration is more than the ability for a patient to receive two different services in one location. So much of what we do now, and what we aspire to do in the future, depends on our ability to better define the role of behavioral health in the overall healthcare system. It depends on our ability to better coordinate and integrate our own core areas- mental health, substance abuse treatment, health promotion and prevention. To take the next steps in behavioral health integration we need to move from program frameworks and policies that create systems to work independently of each other and support full practice transformation.

- Identify, standardize and disseminate integration best-practices across the region
- Support robust evaluation of integrated practices (includes data management, centralized analytics)
- Monitor progress along an integration continuum
- Identify and address operational, financial, and system barriers associated with integrated practice transformation

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the Integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	X	☐	There are continued exclusions, and then a "fight" over who will pay for which services. If there are certain diagnoses that each "camp" would cover, we would like those outlined.
Different behavioral / physical health reimbursement	X	☐	It will be important to make sure the reimbursement rates are equitable if we are providing similar services.
Institutions for Mental Diseases exclusion	X	☐	We are advocating for parity with the institutes in line with the PH hospitals.
OBH rules, reporting, or financing (regulatory differences between agencies)	X	☐	It would be helpful if all the regulators had similar rules. Currently, Medicaid has different rules than OBH – this makes it tough to manage all the requirements.
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	X	☐	It would be helpful if SUD and MH and medical all had consistent privacy laws.
Professional / cultural divisions	X	☐	There are cultural divisions among PH and BH providers. This could be addressed by focus groups or work groups.
RCCO or BHO contracts	☐	☐	
Staff capacity	X	☐	We need a more robust workforce. We need to have improved reciprocity rules for practitioners entering our state.
State/Federal rules or reporting requirements	X	☐	Consistency would allow for easier integration.
Technical resources / data sharing	X	☐	Data sharing requirements and needs should be consistent. We should not have to enter information into several different databases.
Training	X	☐	Training is necessary as it will address the cultural concerns as well as enhance staff capacity in an integrated setting.

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?
http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Population based screenings are a key component of a fully integrated system. It will be important to have a set of screenings everyone uses to track outcomes consistentiy across regions. It may aiso be necessary to develop systems for individualizing the screenings by region.

Having Behavioral Health Providers on site less than 50% of the time does not support the integration process. There needs to be an understanding of the continuum of care and provide a team-based approach that keeps the client/patient at the center of care.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?
   - Care coordination is the deliberate organization of care activities involved in a patient's care to facilitate the appropriate delivery of health care services. It also includes patient empowerment and involvement in their own care in order to ensure adherence to treatment protocols.

b. How should RCCOs prioritize who receives care coordination first?
   - Prioritizing patients who receive care coordination can lead to patients "falling through the cracks" and may cause higher costs later in the treatment provision. Every patient should be eligible for care coordination. It will be up to the providers and the RCCOs to address care coordination needs of the population.

c. How should RCCOs identify clients and families who need care coordination?
   - Care coordination should occur at the primary care (bi-directional) level for anyone accessing more than one health care system by utilizing Health Care Data and Assessments. Care coordination should work with patients who have been identified with multiple care needs.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?
   - It will be important that any tracking of these services is built upon current data structures and reporting. This reporting should not add much administrative burden to the providers.

12) What services should be coordinated and are there services that should not be a part of care coordination?
Services that impact the members' health should be coordinated. This can and should include social determinants of health as well as direct physical health needs. It is important that members get support to remain healthy outside of the physical health care realm.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?
It is imperative that the care coordinators know where and how the patient engages in all aspects of his/her health care – primary and behavioral health care. Specialty health care should be assessed through the primary care provider and coordinated by the RCCO. It will also be necessary to know the patient's medical history and current needs in both behavioral and physical health care in order to prioritize with the team and the patient to meet the most critical needs first as well as address any social factors in his/her health.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?
   - Care coordination (without a shared definition) is happening in private practices, in early childhood settings, in schools, in behavioral health, in public health, in hospitals, and probably in other social services settings. It will be imperative to incentivize and award the RCCOs for developing a systematic approach that meets community needs for care coordination provision.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

   - As a mental health center, we already coordinate care for our clients. Sometimes, this care coordination conflicts with the care coordination required by the RCCOs. We have been working with the RCCO to make this an effective process for our clients. There may also be requirements for Public Health and FQHCs to provide care coordination in addition to the RCCO/ACC. Recently, there have been some funding/grant sources applications that require care coordination – these grants and funding streams often do not specify that care coordination may be being provided in multiple areas. It will be important for the RCCOs to lead the way in identifying how care coordination should be coordinated in order to appropriately and effectively serve the members.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

   - It makes sense to have the care coordination driven from the place of service where the patient feels most comfortable. A patient without a behavioral health concern may be best served through a primary care setting while the opposite may also be true. It is imperative to take the patient's current state in to consideration and if they have other human services needs, the behavioral health provider may be the most appropriate fit.

d. What are the gaps in care coordination across the continuum of care?

- Gaps are occurring when a patient has multiple Care Coordinators who are not working with each other. There are also care coordinators providing coordination for only one specific area that falls into their specialty or knowledge base rather than providing coordination for the whole array of services the patient needs.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

It will be important to identify the needs members have in these "non-medical" areas that directly impact their health care. It is unnecessary to have the RCCOs address non-medically impactful social needs.

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	X	
Affordability (assistance with prescriptions or co-pays)	X	☐	☐	
Daycare / childcare	☐	X	☐	
Economic stability & employment	☐	X	☐	
Education	☐	X	☐	
Environment	☐	X	☐	
Food access / nutrition	☐	☐	X	
Health literacy	X	☐	☐	
Housing	☐	X	☐	
Language or translation services	X	☐	☐	
Literacy	☐	X	☐	
Transportation	☐	X	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) Requirements about who should be doing care coordination. Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these Individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☒	
Certified Addiction Councilors	☐	☒	
Certified Nurse Midwives	☐	☒	
Community Health Workers	☒	☐	Depends on the structure and capacity of the organization
Generalists (BA/BS/MA/MS)	☒	☐	Depends on the structure and capacity of the organization
Health Coaches	☒	☐	Depends on the structure and capacity of the organization
Licensed Clinical Social Workers	☐	☒	
Licensed Marriage and Family Therapist	☐	☒	
Licensed Mental Health Counselors	☐	☒	
Licensed Professional Counselor	☐	☒	
Masters of Public Health	☐	☒	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☒	
Nurse Practitioners	☐	☒	
Patient Navigators	☒	☐	Depends on the structure and capacity of the organization
Peer Advocates	☒	☐	Depends on the structure and capacity of the organization
Promotoras	☐	☒	
Psychiatrists	☐	☒	
Psychologists	☐	☒	
Registered Nurses	☐	☒	
Social Workers	☒	☐	Depends on the structure and capacity of the organization
Wraparound facilitators	☒	☐	Depends on the structure and capacity of the organization
Other	Care coordination should be placed with the provider most appropriate for that client/patient.		

- Care coordination should be offered by a staff member who can operate as a generaiist and who can integrate and faciiitate connection to resources that will address the social determinants (health, jobs, housing, Income, and social or famliy relationships) as a fundamental component of care planning in order to increase rates of client recovery and improve the client's quality of life. Care Coordinators have to have a skill set that supports and increases the patient's motivation to engage in a partnership with their health care team.

17) Care coordination requirements for specific populations. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and Infants	☐	X	
Children	☐	X	
Children who are healthy, but in socially-complex environments	☐	X	Define socially complex.
Children involved in the foster care system	☐	X	
Children with a chronic illness	☐	X	
Children with a serious emotional disturbance	X	☐	Care should be coordinated by the BHO
Children with medical complexity	☐	X	
Children or youth with a behavioral health diagnosis or substance use disorder	X	☐	Care should be coordinated by the BHO
Transition-age adolescents	☐	X	
Parents and families	☐	X	
Pregnant women	☐	X	
Adults	☐	X	
Adults who are healthy, but in socially-complex situations	☐	X	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	X	☐	Care should be coordinated by the BHO
Clients involved in the criminal justice system	☐	X	
Clients with a disability	☐	X	
Clients in a nursing facility	☐	X	
Elderly clients	☐	X	
Frail elderly clients	☐	X	
Clients in palliative care	☐	X	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

The RCCO should only be involved if there are medical issues that need to be addressed.

19) How should care coordination be evaluated? How should its outcomes be measured?

Care coordination outcomes should be measured by a decrease in duplicated services, patient satisfaction and achievement of health goals, and a decrease in costs to the system.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

We would request an actuarial analysis to determine this.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

We would request an actuarial analysis to determine this.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

We believe the analysis mentioned above will drive the client to care coordinator ratios.

a. Care coordinator to client ratios. If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	X
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

One of the most important aspects to measure is the decrease in cost of providing services if they are coordinated. It will also be Important to measure health outcomes achieved like increase in function and Improvement on the population based assessments and screenings.

23) Piease share any other general advice or suggestions you have about care coordination in the ACC.

It is Important to remember that care coordination Is most effective when It is provided at the point of care and that it needs to be flexible enough to meet the patients' needs. We need to focus on better health outcomes and reduction of cost because of thls coordlnation for patients with muitiple chronlc health conditions.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

While there is benefit to requiring things like data requirements and defining care coordination activities, it is important to remember that one of the most successful aspects of the RCCO model has been the local control to provide localized solutions, and too much regulation in this area would hinder that success. We believe that allowing the RCCO to determine the provider contracting and payment methodologies can create a cost saving system by creating competition to provide services.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Community relationships are an important piece to a successful RCCO. It would be our preference that bidders identify their current strengths and weaknesses in this area rather than the RFP requiring certain actions be undertaken. Prescriptive community building may be easier to "measure" because bidders can check items off for the partners at the table, but it does not truly show the impact of the relationship. It will be important for bidders to identify the areas in the relationships they need to enhance and those that are going well and how those will be maintained.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This would be very difficult in rural and frontier areas. We also believe this would be difficult to track and maintain as some of the data we have been exposed to shows that the identified PCMP may not even know the patient or have seen the patient in several years.

27) Should the RCCO region maps change? Why or why not? If so, how?

It should be considered that RCCOs 4 and 7 be combined as these two geographic areas relate to patient migration and various types of care. RCCOs 4 and 7 have much in common when it comes to consumer choices. A great portion of RCCO 4 is geographically isolated by large expansions of grasslands and mountains. This reality is compounded by sparse isolated population centers with limited consumer choice. The historical patterns are for these isolated communities to migrate to Pueblo and Colorado Springs A combining of both regions would validate historical patterns that were set into motion by the need to have better and more choices for care. Currently, our BHO is functioning in these two RCCOs and we feel it could be beneficial to combine for better management of outcomes as well as consistency among providers. It will be necessary to look at where and how patients are currently accessing care to see if this makes sense for the patients.

28) Should the BHO region maps change? Why or why not? If so, how?

The BHO contract would have to be re-bid if this were to occur. The BHOs have been in place for a very long time and this could negatively impact the clients if this were done. There would need to be a lot of

education and support for this transition to occur. It would also be our hope that the State would be ready to combine the BHO and RCCO programs. The disruption to our clients that could occur if they were not combined and the maps changed could be very detrimental to the recovery that is already in place.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

6 months would be the minimum transition period necessary. We would imagine that education, marketing and patient support would be integral in ensuring a smooth transition. The expenses would need to be identified by the new vendor, but should include outreach and support to patients in addition to operational needs.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

We believe that moving toward a risk based contract would support the decrease of costs and increase population health management. If providers were to receive a PMPM, they could develop supports and systems to meet their population's needs and create operational structures that would be sustainable. It would be advisable to add access and quality measures to the PMPM structure. We believe these measures would dramatically impact the health of the members and show a cost savings early in its implementation.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

There is some discrepancy on billing for the 99000 and the HCPC codes because of credential issues of the providers. There is also no ability to provide co-located services. We would recommend that all services that can be provided at the Mental Health Centers can also be presented in other facilities by our providers.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

We do not believe this would be feasible in the rural and frontier areas. There is not enough population to support two RCCOs. This would also cause problems in tracking and monitoring patients if they switched between RCCOs on a continual basis. Care coordination and service provision would prove difficult to monitor and ensure quality. This would also cause regional service providers to be involved in more than one RCCO and manage the reporting requirements for both that may be different or in conflict at times. Providers would need to split up patient populations and this would require administrative oversight and coordination. We think this would prove very difficult to manage in our area.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

Not Applicable

34) What role should RCCOs play in attributing clients to their respective PCMPs?

Currently, care coordinators do this by providing education and coordination in getting patients attributed to or utilizing a PCMP. We believe RCCOs should support his by working with patients to attribute them to a provider that can meet their needs and serve them in their own community.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

We do not know of any.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

It is important to remember the ancillary services that impact the physical health of the patients in the RCCO. CDHS supports the use of funds to assist patients with their social/emotional needs. Supportive behavioral health services will need to maintain their funding to increase positive health outcomes for the patients who are in both systems. State level offices (HCPF and OBH) should work together to support the provision of comprehensive health care.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

We believe that Medicaid is a large task for the RCCOs to manage and that if they were to work with other insurances, that should occur in the future, not in this current RFP.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

If the decision is made to move to risk-based contracting, the Division of Insurance would need to be involved.

DORA will be instrumental in increasing the number of qualified behavioral health professionals entering Colorado. It would be helpful for the ACC program to look at the length of time it takes to have a license from another state transfer into Colorado. As integrated care becomes more prevalent and codes are increasing, DORA may need to consider how they will license integrated facilities.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakehoider engagement with clients, clients' famiiies, and client advocates?

Similar to our belief about community engagement and understanding, the RCCOs need to address how they wiii engage stakeholders, but not be required to compiete a prescriptive process. It is important for the bidders to identify their strengths and weaknesses in this area as well as their plans for future invoivement. Each RCCO should identify how stakeholders will be engaged in a meaningful way that works for the iocal community and meets the needs of the providers as well as the patients.

40) What specific requirements shouid RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

Again, we do not believe there should be prescriptive requirements built in, but rather a process defined by the RCCO in order to meet the needs of the community.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

Bidders need to Identify how they wiii work with the local community to increase communlty engagement. The bidders should be awarded in the RFP for Identifying current community involvement and measured on their pians for increasing the engagement.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Please see our answer to questibn 39.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?
No

a. If no, what are the gaps?

- Access to specialty care in rural/frontier parts of Colorado is a problem. Home health care providers as well as non-medical providers are lacking in rural Colorado.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

- The elderly and home bound populations need more support in our communities. There is also a shortage of child psychiatrists.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?
   - Hospitals need to ensure that care coordination and data sharing in real time occurs with the RCCOs. It is necessary to allow the care coordinators for the RCCO access to this information to reduce the length of hospital stays and costly services.

b. What role should pharmacies play in the next iteration of the ACC Program?

   - Pharmacies may be used to alert the RCCOs and/or PCMPs and care coordinators to suspicious prescribing activity or "doctor shopping."

c. What role should specialists play in the next iteration of the ACC Program?

   - Specialty care needs to be more accessible in rural/frontier counties. The ACC program should provide incentives to specialists to provide care in these areas. The expansion of tele-medicine should be strongly encouraged. If tele-medicine is encouraged and incentivized, there must be funding for marketing and education to the patients as there is still a mistrust of this practice in rural and frontier areas.

d. What role should home health play in the next iteration of the ACC Program?

   - Home health should be a central part of care planning. Hospitals should be required to work closely with home health agencies.

e. What role should hospice care play in the next iteration of the ACC Program?

   - Hospice care should be readily available to all patients in the ACC program.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

   - These organizations should be required to work closely with ACC when patients are

transitioning care. It is necessary to have strong care coordination efforts with this population.

g. What role should counties play in the next iteration of the ACC Program?

- County agencies that set clients up with their benefits need to ensure that patients have the information needed to access health care and recognize they may be involved in multiple care provision systems, including DSS/DHS benefits. It is also imperative that the counties help clients transition their benefits to the appropriate county if a move or other transition occurs.

h. What role should local public health agencies play in the next iteration of the ACC Program?

- Public health agencies need to be an integral part of the referral resource for the ACC program. It should also be noted that they may have different care coordination requirements placed upon them and the systems that fund both public health and the RCCOs need to be coordinating requirements in these areas.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

- RCCOs need to know the providers in the area and it should be noted that only organizations that can impact health outcomes should be tapped for the ACC program and it should be simple for the patients to access their care and not get overwhelmed by too many organizations providing similar services.

45) How can RCCOs help to support clients and families in making and keeping appointments?

It would be helpful to look at systems that have worked. Our MHC system has devised appointment outreach and support for our clients. It may be helpful to look at how the MHCs have increased appointment attendance and support for clients in this area. We work with the clients and their scheduling requirements rather than dictating when they must come back to see us. This is where a care coordinator could be helpful.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

It will be important for the RCCOs to identify what solutions will work best in their community. Requiring such a prescriptive measure may not be beneficial for the systems that are already proving effective in communities.

47) **Community Health Worker reimbursement. Please use the table below to detail how Community Health Workers should be reimbursed:**

The RCCO should determine this in their bid for the RFP.

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

Oral health is a primary component of health care. The RCCO should ensure this care is integrated in the overall health care for the members.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?
   - This means providing culturally responsive and appropriate services. It means meeting the patient and family "where they are" and guiding them through the health care system in a way that works for them and supports their overall health goals (even if they may be at odds with "traditional" methodologies).

b. What RCCO requirements would ensure cultural competency?
   - It is important for the RCCOs to identify how they meet this need in their communities. Requirements of this type that are too prescriptive do not lend themselves to the flexibility needed to be culturally responsive.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?
   - Organizations must be able to demonstrate previous successes in this area as well as the desire to continually improve and meet the needs of the populations they are serving. Low health literacy is a concern, but can be met with culturally responsive organizations and values. It cannot be driven by mandates.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

- It is important that every patient is treated with the respect and support s/he needs to be successful as s/he defines it. This may mean that sometimes cultural beliefs and necessary supports do not lead to the "health outcome" we (the dominant culture) have identified as a positive. It will be important for the RCCOs to identify health outcomes that increase population health, but also support community needs and beliefs.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

The RCCOs should address what the needs are regionally. This should be part of how the bidders demonstrate their knowledge and support of their region. It will also differ depending on the urban or rural settings that are served.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Real-time data to provide better care coordination will be necessary to mitigate these costs.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	X	☐	☐
Network provider education	☐	X	☐	☐
Assistance with practice redesign	☐	X	☐	☐
Assistance with efficiency-enhancing activities	☐	X	☐	☐
Provide web-based resources and directories	☐	X	☐	☐
Provide practice-specific data reports	☐	X	☐	☐
Provide clinical care guidelines and best practices.	☐	X	☐	☐
Provide clinical screening tools	☐	X	☐	☐
Provide health and functioning questionnaires	☐	X	☐	☐
Provide chronic care templates	☐	X	☐	☐
Provide registries	☐	X	☐	☐
Offer client reminders	☐	X	☐	☐
Offer client self-management tools	☐	X	☐	☐
Offer educational materials about specific conditions	☐	X	☐	☐
Supply behavioral health surveys	☐	X	☐	☐
Supply other self-screening tools	☐	X	☐	☐
Administer behavioral health surveys	☐	X	☐	☐
Administer other self-screening tools	☐	X	☐	☐
Prepare client action plans	☐	X	☐	☐
Provide training on providing culturally-competent care	☐	X	☐	☐
Provide training to supporting staff	☐	X	☐	☐
Provide training on motivational interviewing	☐	X	☐	☐
Provide tools and software for phone call and appointment tracking	☐	X	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	X	☐	☐
Provide referral and transitions of care checklists	☐	X	☐	☐
Provide visit agendas or templates	☐	X	☐	☐
Provide standing pharmacy order templates	☐	X	☐	☐
Provide comprehensive directory of community resources	☐	X	☐	☐
Provide directory of other resources	☐	X	☐	☐
Provide materials regarding Nurse Advice Line	☐	X	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	X	☐	☐
Others	We do not believe the state should require any of these items, but instead leave them up to the RCCO to determine what best fits their regions' needs.			

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

N/A

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

RCCOs should identify their ideas about how best to do this in their region.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

We believe a risk-based program will facilitate this.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

NO

58) Please share any other advice or suggestions about provider support in the ACC.

RCCOs need to be able to identify what will work/has worked in their region. We do not believe it is necessary to be prescriptive about how to accomplish the goals as long as the goals are agreed upon. The goal should be an overall increase in population health and decrease in costs. Let the RCCOs work with and in their communities to develop and present culturally responsive and adequate solutions to local needs.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?
A risk based contract should be considered. The PMPM could be managed against population health outcomes and lower costs.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

We are not primary care providers but our BHO has operated for 18 years by having providers take risk. We think this system of financing providers can work for primary as well. Our success in using capitation leads us to believe this would be a successful model for primary care as well.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

No they are not. The biggest barrier is the fee for service system of reimbursement. The medical system in place currently is set up to generate volume not value, a fact that is known to anyone who has worked to reform the health care system. The biggest barrier is that there are no incentives for providers to move to a system that is based on value. In fact providers are penalized if they focus on value. The infrastructure will not be developed until the incentives for producing value are aligned with the payment structure. This transformation can best be achieved by introducing risk contract to the RCCOs that reward value rather than volume. I hope this can be done in the next RCCO bid. It will be important to give providers who are currently used to a volume based fee for service model time to adjust to providing value for the services. It will also be important to define value in a way that can be measured appropriately. It cannot be based on the number of services provided, but must be based on quality of care outcomes and the elements that providers can influence.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

N/A – we are part of a BHO that could potentially bid. Our BHO is licensed by the DOI and we are ready and able to acquire any needed license and the required reserves.

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

We believe RCCOs should be entirely responsible for the distribution of payments to providers they manage and monitor.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

Capitation payments (PMPM) with rate setting factors that reward quality.

66) Measuring Client experience. Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	
SF-12 Health Survey	☐	☒	SLV has opted out of using the SF-12 as a pre and post measure.
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☒	☐	
Focus groups	☒	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

Population health should be the responsibility of the RCCOs, but must be funded through the state system. There should be a change in claims data that shows health improvement trends. If population based screenings are implemented, this data can and also should be used.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

Quality and performance should be easily accessible for anyone. It should be available via a website as well as by patient request and data should be included in our annual reports. The RCCO could define parameters to report on and we would be required to comply.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	X
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	X
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

There should be a combination of KPIs for all RCCOs and some local indicators.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

We think there could be a system to reimburse based on both performance & improvement.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

The claims issue should not restrict payment. Systems can be instituted by the RCCOs to monitor progress outside of the claims data.

74) Incentive payment frequency. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	X
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

I don't know the fixed costs of operating a RCCO but I do know the fixed costs of operating a BHO which might have some similarities. The BHOs are required to have access standards for routine, emergent and emergency care along with access to providers within acceptable driving distances. In order to meet these standards we have to over staff. This is one example but there are many such requirements in our current contract that drive cost. RCCO RFP requirements will drive fixed costs. That state should evaluate very carefully the whether these requirements will generate value to the health care system.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

We are currently evaluated on 28 measures, but reimbursement is not tied to these. As a member of the BHO, we believe it is desirable to have these measures included in rate setting. If the state chooses to move toward risk-based contracts for the RCCOs, we believe quality measures should be tied to the rates.

Health information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	x
Text message	☐	x
Web portal	☐	x
Email	☐	x
Telemedicine / Video chat	☐	x
Face-to-face meeting	☐	x
Smartphone app	☐	x
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	X
Digital care management tool	☐	x
Care transitions alerts	☐	X
Electronic Health Records (EHRs)	X	☐
Health risk assessment software	☐	X
Practice assessment tools	☐	X
Practice management tools (scheduling, billing)	X	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	X
Patient education/wellness tools	☐	X
Provider/case manager directory	☐	X
Shared decision-making tools	☐	☐
Telemedicine software	☐	X
Other:	☐	☐
Other:	☐	☐

79) Importance of technology by type. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	X	☐
Care management tool	☐	☐	☐	☐	X
Care transitions alerts	☐	☐	☐	☐	X
Electronic Health Records (EHRs)	☐	☐	☐	X	☐
Practice assessment tools	☐	X	☐	☐	☐
Health risk assessment software	☐	☐	X	☐	☐
Practice management tools (scheduling, billing)	☐		☐	X	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	X	☐	☐	☐
Patient education wellness tools	☐	☐	X	☐	☐
Provider/case manager directory	☐	☐	☐	X	☐
Shared decision-making tools	☐	☐	X	☐	☐
Telemedicine	☐	☐	☐	☐	X
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health information Technology to improve the performance of Primary Care Practices?

One of our biggest barriers is our current EHR system. There is a lack of philosophical connection and understanding of the purpose of the tools and how they assist to manage or impact patient care.

Another barrier would be using multiple software tools for care coordination. It will be important to make sure the software requirements either fit into current systems or are completely separate (which is another barrier to quality care).

81) How can Health Information Technology support Behavioral Health integration?

In order to have true integration, the technology needs to be integrated as well. We need to figure out how to protect client information in a way that still allows care to be driven in one record.

As tele-medicine becomes more important in rural and frontier areas, care will need to be taken with how this is introduced and disseminated to patients. It will also be necessary to ensure the communities have the technological infrastructure to support web-based platforms. Currently, there is not consistent internet access throughout the San Luis Valley.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

We believe the system should be shared. It must include the ability to report behavioral health data and physical health data. The data must be transferred to the state on a common platform, but it may be beneficial to allow the RCCOs to develop their own systems that meet the state requirements.

The RFP could require that RCCOs track cost of care; health outcomes and other health outcome measures and be able to transmit these data in a common platform.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

Yes, we would endorse a shared care management tool, which should be fully integrated with the EHR, as well as have technology tools to support the patient.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.
Although the population health management tool should be the responsibility of the RCCO, the tool could be integrated into EHRs. This way, the information can be accessed by current providers.

The tool could look at the overall use of care by a population and identify duplicate and inappropriate care so that these trends can be addressed with the providers in the network.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.
The Connect for Health Colorado resource guide is a good model. I would want to make sure that we move beyond thinking everyone has technology at their fingertips & have kiosks available in provider locations or distribute in a different fashion.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

Transparency & ease of use, which is currently a barrier.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

We believe a combined primary and behavioral health EHR that is easy to use and understandable to all providers. We should have access to all data in our RCCO in order to provide better care to our patients. We should not have to jump through hoops to get the data.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

We would like to see a system that works across platforms that is as accessible to providers as it is to the patients. It is important for this data to be accessible and transparent to the users.

Right now, CORHIO can be "opted out" of by patients. In order for this system to work, there should be mandates about participation.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

it would make sense to have all provider members of the RCCO use CORHIO or QHN. Currently, not all of our partner organizations use CORHIO and this limits the data exchange we can have for our shared patients.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Currently providers like working with their own EHR and pulling data rather than dually documenting into different systems. With the information exchange systems we currently work with the information added to the exchange is limited and does not support comprehensive sharing of resources or health information.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 058

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Brad Young
Location: 3660 Wadsworth, wheat Ridge, CO 80033

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Rx Plus Pharmacies, Inc.
Location: Wheat Ridge, CO 80033
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☒ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☐ Yes
☒ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Rx Plus arranged to have Joe Moose, a pharmacist from North Carolina who contracts with Community Care of North Carolina, make a presentation to the RCCOs concerning how community pharmacists can add value by helping patients increase adherence and by providing Comprehensive Medication Management for patients with complicated health problems.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Rx Plus has worked closely with Colorado Medicaid on the current pricing methodology for pharmacy. We also have communicated and lobbied on Medicaid issues impacting the Pharmacy program

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☒ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Rx Plus, along with the chain pharmacies and the Colorado Pharmacists Society, has been advocating a more active role for pharmacists in the RCCOs for several years. We believe that since patients see

their pharmacists more regularly than other health care providers, community pharmacists are in a unique position to provide comprehensive medication management, which has been demonstrated to help with adherence, improve transitions of care, and provide patient education and counselling. We would like to play a more active role in that capacity. Many pharmacies are using newly developed telecommunication tools that are designed to assist in that role (suc as Prescribe Wellness). We continue to believe that pharmacists in all settings, including retail community pharmacists, can and should play a much more significant role in the RCCOs to help improve heal outcomes for patients.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?
2) What is not working well in the ACC Program?
3) What is working best in the Behavioral Health Organization (BHO) system right now?
4) What is not working well in the BHO system?
5) What is working well with RCCO and BHO collaboration right now?
6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

   a. What is the best definition of care coordination?

   b. How should RCCOs prioritize who receives care coordination first?

   c. How should RCCOs identify clients and families who need care coordination?

   d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

   a. What care coordination is going on today?

   b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

   c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

   d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	
Health literacy	☐	☐	☐	
Housing	☐	☐	☐	
Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	
Transportation	☐	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Pharmacists should play a role in coordination and transition of care.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

    a. What is the PMPM cost for providing care coordination services?

    b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

    a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

   a. If no, what are the gaps?

   b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

   a. What role should hospitals play in the next iteration of the ACC Program?

   b. What role should pharmacies play in the next iteration of the ACC Program?

Rx Plus, along with the chain pharmacies and the Colorado Pharmacists Society, has been advocating a more active role for pharmacists in the RCCOs for several years. We believe that since patients see their pharmacists more regularly than other health care providers, community pharmacists are in a unique position to provide comprehensive medication management, which has been demonstrated to help with adherence, improve transitions of care, and provide patient education and counselling. Many pharmacies are using newly developed telecommunication tools (such as Prescribe Wellness) that are designed to assist in that role. We continue to believe that pharmacists in all settings, including retail community pharmacists, can and should play a much more significant role in the RCCOs to help improve heal outcomes for patients. We look forward to discussing the possibilities with you.

   c. What role should specialists play in the next iteration of the ACC Program?

   d. What role should home health play in the next iteration of the ACC Program?

   e. What role should hospice care play in the next iteration of the ACC Program?

   f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

   g. What role should counties play in the next iteration of the ACC Program?

   h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47) **Community Health Worker reimbursement**. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Rx Plus sponsored Joe Moose, a pharmacist from North Carolina, to make a presentation to the RCCOs last March. Dr. Moose is available to work with the RCCOs and Colorado pharmacies to help integrate pharmacists from all settings into the coordination of care model. He has had extensive experience providing such services in North Carolina with their Medicaid program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 059

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Louise Delgado, CEO
Location: Canon City, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Solvista Health (Formerly West Central MHC)
Location: Southern CO
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Individual
☐ Individual's family member
☐ Individual advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Behavioral Health
  ii. Area of practice: Mental health, health, substance use
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☒ 2-3 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
We are in a partnership with our RCCO (ICHP) Region 4

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Behavioral health provider covering 4 rural and a frontier county in Southern Colorado.

If you are a individual, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

☐ 3-4 years
☒ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

   - We are local, comprehensive, community based health care staffed by professionals within our communities. We are familiar with the needs, barriers, and resources and can often assist in gaining access to care.

2) What is not working well in the ACC Program?

   - Complexity of systems and lack of knowledge across systems.
   - Data is vast and very diverse. Often untimely and irrelevant by the time we receive it.
   - Key partners are not provided incentives for being involved and helping us meet our KPI's that will impact triple aim.
   - Payment structure redefined or incentives aligned- individuals do not pay co-pay for emergency dept. vs. primary care.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

   - Data is readily available and usable. The experience of the BHO is very helpful. BHO's have experience and work at controlling cost while being at risk.

4) What is not working well in the BHO system?

   - The feel of services being based on a more fee for service model- versus focusing on the full continuum of care we offer to all of our members.

5) What is working well with RCCO and BHO collaboration right now?

   - The joint RCCO – BHO meetings have been very productive as we are the most familiar with our communities and what we have already initiated through our work with the BHO. We work closely with our BHO and RCCO partnerships, often cross training to ensure all needs are being met.

   - Shared positions between RCCO and BHO has assisted in smooth transitions.
   - BHO experienced has been an added benefit in developing programs and partnerships and data gathering and sharing.

6) What is not working well with RCCO and BHO collaboration right now?

- Progress in data sharing between systems- being able to access SDAC on behavioral health side. .

  SDAC Data is very delayed data- often we are not aware of imminent concerns. Emergency visits, changes in medical needs, are not reported for 4 months.

- Additional Data is not being shared across systems that could be helpful. For example the BUS system through DHS maintains long-term care plans, HCBS applications, etc...

- Multiple assessments by different entities is difficult for the individuals. It is a duplication of services. Examples: DHS assessments, Service Coordination Plans (SCP's), long-term care plans, Developmental Disabilities plans.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- Integrate data and include behavioral health data.
- Increase primary care and dental providers within Colorado. Reward providers for higher levels of integration.
- Increase access to providers.
- Resources to address the social determinants such as housing, nutrition, transportation.
- Ensure that advocacy, patients and providers are at the table with policy makers.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	Barrier? No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	Ultimately, this comes down to how a service is coded which does not support the use of USCM. This is often reflective of a fee for service model versus
Community Behavioral Health Services Rule	☒	☐	USCM and the OBH regulations do not support this type of service.
Covered diagnoses list	☒	☐	Identifying how we can assist in coordination of individual's care- regardless of diagnosis.
Different behavioral / physical health reimbursement	☐	☒	The reimbursement model is impacting in regards to getting providers.
Institutions for Mental Diseases exclusion	☒	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	The OBH rules and USCM do not assist in integrated care. They are not focused integrated care.
PCMP financing structure	☒	☐	Format of payment could be improved. Through RCCO, the PCMP receives a single payment and have limited knowledge of the additional dollars. Do not understand roles and responsibilities. Differentiating the pay for them would assist.
Per-member per-month amount	☐	☒	
Physical space constraints	☒	☒	Smaller practices in rural areas is a very real concern as they are often working within very small spaces.
Privacy Laws (HIPAA, 42 CFR)	☒	☐	The enforcement is where it becomes difficult. The technological issues are a problem.
Professional / cultural divisions	☒	☐	This is one of the many challenges we have found. The BHO and MHCs have some very rich experience in this area. Mental/Behavioral health still carries a significant stigma- particularly in rural areas.
RCCO or BHO contracts	☐	☒	

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Staff capacity	☒	☐	Staff capacity is an issue in every area of healthcare due to limited work force. .
State/Federal rules or reporting requirements	☒	☐	The reporting requirements need to be aligned.
Technical resources / data sharing	☒	☐	Up to date data and more access to data sharing.
Training	☐	☒	
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

Utilizing the 6 levels of integration as well as providing a "no wrong door" approach to overall care, the use of a shared record, holding each provider to the same level of accountability and incentives for care coordination. Finding integrated services is key.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

In our rural locations, the PCMP's do not know the expectations and requirements. The BHO is further advanced in this and the value of outcomes for individuals.

Care Coordination

11) Care coordination is an important part of the ACC Program.

- What is the best definition of care coordination?

  Collaborating with the individual to improve quality of life, health outcomes, and reduce costs. A key goal would be to help the individual receive care coordination within their community.

- How should RCCOs prioritize who receives care coordination first?

  Due to resources and capacity it is necessary to prioritize care coordination services. In order to identify the population that care may be able to impact the most effectively- we have focused on individuals who have conditions we can influence via coordination and environmental factors. There is currently a focus on individuals in the middle of bell curve to prevent higher cost of services.
- How should RCCOs identify individuals and families who need care coordination?

  Care coordination is the most effective when it is occurring when someone enters *any* door for care and ensuring they are linked to appropriate levels of care- whether it be preventative, early intervention, or more complex. The individual should be allowed to identify or designate who they feel the most comfortable working with.

- How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

  The requirements should be standardized regardless of who is providing the service.

12) What services should be coordinated and are there services that should not be a part of care coordination?

- All services should be coordinated including services outside the medical visit, Social Services and Public Health.
- In addition the social determinants are also key to well-being. Health, lifestyle, education are key components.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

- Real time data access to health care services including prescriptions and ER visits related to the individuals care.
- Accurate contact information- some information is years out of date on current lists.

14) Many individuals and their families have access to a number of different care coordinators. These coordinators often work in different systems.

- What care coordination is going on today?
- Medical, behavioral, referrals to specialty, including helping meet additional needs. .
- What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

  We work in coordination with our RCCO and within our system to ensure that an identified agency/person takes the lead to ensure individual has their care coordinated. We have established relationships with local providers (SEP's, DD,EPSDT, Waiver programs) as well as the RCCO and have been providing this level of care through our BHO contract. Our role has been to ensure on any level we must coordinate care for our individuals in our communities to prevent further risks and costs. Our role, as a BHO provider, has been key to ensuring the individual gets the care they require while reducing costs.

- How can the ACC avoid duplicating or disrupting current care coordination relationships?

  Improved ability to data share would result in a reduced duplication of work and reduce the duplicity for the individual. Centralizing care coordination through the RCCO would assist with this.

- What are the gaps in care coordination across the continuum of care?

  Currently, a lack of data sharing and access to the key data systems, such as SDAC, with real time data sharing would improve the efforts. The collaboration between providers and care coordinators would improve if we had access to real time data and actions taken on behalf of individuals. Due to complex needs, it can take 10-12 contacts to understand who all may be involved in individuals care as the data systems may be 3 months old.

COs' roles in addressing individuals' and their families' non-medical needs. Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	**Should the RCCO have a role?** Yes	No	**Should the RCCOs coordinate with community supports and services?** Yes	**Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?**

Abuse, neglect, and trauma	☐	☐	☒	
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	**We have a role in connecting individuals even if it is through PAP programs.
Daycare / childcare	☒	☐	☒	**Assist and link individuals to this.
Economic stability & employment	☐	☐	☒	**Always linking individuals to resources and accessing healthcare, including PEAK system.
Education	☐	☒	☒	**We link individuals to resources for GED, online schooling, etc...
Environment	☐	☐	☒	
Food access / nutrition	☐	☐	☒	
Health literacy	☒	☐	☐	
Housing	☐	☒	☐	
Language or translation services	☒	☐	☐	
Literacy	☒	☐	☐	
Transportation	☐	☒	☒	
Other	In providing individualized care, we address many of these needs- Maslow's hierarchy of needs must be addressed before a person can meet other needs including overall health care. This includes housing, transportation, education, and food.			

15) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Individuals and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?

Advanced Practice (Registered) Nurses	☐	☒	
Certified Addiction Councilors	☐	☒	
Certified Nurse Midwives	☐	☒	
Community Health Workers	☒	☐	Working within organization and community.
Generalists (BA/BS/MA/MS)	☒	☐	Working within organization and community.
Health Coaches	☒	☐	Working 6+within organization and community.
Licensed Clinical Social Workers	☒	☐	Provide a component of care or linkage as presented in care through BHO.
Licensed Marriage and Family Therapist	☒	☐	Provide a component of care or linkage as presented in care through BHO.
Licensed Mental Health Counselors	☒	☐	Provide a component of care or linkage as presented in care through BHO.
Licensed Professional Counselor	☒	☐	Provide a component of care or linkage as presented in care through BHO.
Masters of Public Health	☐	☒	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☒	
Nurse Practitioners	☐	☒	
Patient Navigators	☒	☐	Working within organization and community.
Peer Advocates	☒	☐	Working within organization and community.
Promotoras	☒	☐	
Psychiatrists	☒	☒	
Psychologists	☒	☐	
Registered Nurses	☒	☐	This has been highly successful in knowing how to coordinate care and link to appropriate medical interventions.
Social Workers	☒	☐	Provide a component of care or linkage as presented in care through BHO.
Wraparound facilitators	☒	☐	Provide a component of care or linkage as presented in care through BHO.
Other	A wide variety of needs and backgrounds that may be added on to a team to help meet an individual's needs. Very similar to specialty care i.e. medically complex needs- RN may coordinate care. SPMI individuals may have a social worker or mental health professional, wraparound is also a way to help individuals voice their needs and reduce redundancy.		

16) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☐	
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☐	☒	Care should be coordinated through BHO provider.
Children involved in the foster care system	☒	☐	
Children with a chronic illness	☒	☐	
Children with a serious emotional disturbance	☒	☐	Care should be coordinated by the BHO
Children with medical complexity	☒	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	Care should be coordinated by the BHO
Transition-age adolescents	☐	☒	
Parents and families	☐	☒	
Pregnant women	☒	☐	We work closely building natural supports and follow up for pregnant women, including post-partum screenings through CMHC and Medical.
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☐	☒	
Adults with a chronic illness	☐	☒	
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	Care should be coordinated by the BHO
Individuals involved in the criminal justice system	☐	☒	
Individuals with a disability	☐	☒	
Individuals in a nursing facility	☐	☒	
Elderly individuals	☐	☒	
Frail elderly individuals	☐	☒	
Individuals in palliative care	☒	☐	Ensure needs are met and if care is needed outside of palliative care (return home, ACF, NF).
Other populations, please comment:			

17) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

- The RCCO would have a limited role working with agencies in meeting individualized specific needs but we are very familiar with working in this system on the BHO level as a team. A key component is utilization of ACES (Adverse Childhood Experiences Study) as we impact the ACES it reduces overall costs in later life related to health care, mental health, and substance use.

18) How should care coordination be evaluated? How should its outcomes be measured?

- Reduction of duplicated care and the resulting reduction in medical expenses.
- Ability to show impact in future due to reducing individual's risk factors and education/interventions at this time period.
- Connecting a person to care and early intervention and prevention reduces long term costs.
- Population health screens.
- The key components should help all of the healthcare integration systems align, including the RCCO, BHO and commercial insurance to help achieve goals of our State Health Innovation Plan.

19) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

- What is the PMPM cost for providing care coordination services?

  This is not a question we can answer.

- Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

  Same as above.

20) Should there be care coordinator to individual ratio requirements in the next RFP? How should this vary by individual acuity or population?

21) It needs to vary by population and clients identified within a caseload. If the requirements or complexity are high a lower caseload is necessary.

- Care coordinator to individual ratios. If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered individuals having disabilities, please estimate how many individuals one care coordinator can serve. Please use the table below for your response:

It would be better to not regulate, the higher the acuity the lower the caseload.

Individuals	
Fewer than 25	☐

26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

- Cost of care – reduction in wasted care because of un-coordinated care. Cost only looks to today not future.
- Consumer input regarding cost, experience, quality of life.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

The State needs to be aware of the social determinants and the cost of impacting the population and how would dollar amounts be identified.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Care coordination standards as the resources are limited in rural and frontier communities. We often can't even identify PCMP's. Data reporting between RCCO's and State should be standardized as well as who shares what data within RCCO (i.e. some hospitals share data daily, some will only provide data to RCCO but not provider, etc...)

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

You can't force collaboration but having the bidder identify the formal and informal partnerships and how these are utilized is helpful.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's individuals are enrolled. Please comment on this proposal.

I don't think this will work in rural and frontier areas of the state. We just don't have the population needed to make this work.

27) Should the RCCO region maps change? Why or why not? If so, how?

The State should consider going to fewer RCCO's and consider combining the RCCO's working between Colorado Springs Region(7) and Southern Colorado (Region 4).

28) Should the BHO region maps change? Why or why not? If so, how?

If we were going to integrate the programs into one this would work. Otherwise, it would require a new bid for the BHO to re-align regions. It is beneficial to build on the experience of the BHO's, the local partnering, and risk sharing.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

If the vendors were familiar with our system, they would need approximately one year. During the transition period the local level partnerships would need to be addressed as this is where the work takes place. We had these relationships and worked effectively to partner and meet the needs of the individuals in our communities.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

Identify ways to incentivize providers to assume/manage risk. This will assist in reducing and diverting from unnecessary higher levels of care.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

We need to be able to account for our time services within integrated care and need the codes that support this.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for individuals and providers. If so, why? If so, how many and where? What issues would this address?

I don't think this can work in rural /frontier Colorado, the population could not support two RCCOs.

33) If you or your practice provide services to individuals referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

N/A

34) What role should RCCOs play in attributing individuals to their respective PCMPs?

We have to work on this in order to provide intervention and prevention. This is a key role of care coordinators to help provide screenings, etc....This needs to be completely in a more efficient manner. Currently requires a telephone call with the individual and State. This creates a barrier for individuals.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

CDPHE does provide some oversight/collaboration.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

Mutual communication and collaboration.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

Medicaid is a large task for the RCCOs, we should not put more on them. If credentialing and benefit packages should be streamlined within the marketplace it would be beneficial.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

We do not need added regulatory requirements as we are sorting roles on this. Approval through DORA to be approved in this state is very difficult. It makes it difficult to recruit outside of our 5tate yet due to workplace shortages we must recruit outside of our state.

Stakeholder Engagement

39. What should be required of the RCCOs in terms of stakeholder engagement with individuals, individuals' families, and individual advocates?

We are the most familiar with our stakeholders and need to be able to identify who should be at the table, where, and the best way to meet the need and collect input. This includes allowing families and individuals to have voice and choice related to their care, health care choices, and limiting the regulatory items we must meet.

40. What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

The requirement should be that we are building support for the program and this level of care and that we are engaging stakeholders- the request should be that we are able to provide incentives for everyone coming together.

41. Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

- This can be accomplished through the RFP crediting bidders for community involvement and recognizing the role of historical success in engaging stakeholders within partnerships.

42. How should the Department structure stakeholder engagement for the ACC as a whole?

This should be completed at the community level and engaging individuals, advocates, and community stakeholders/members.

Network Adequacy and Creating a Comprehensive System of Care

43. Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

- No in general to PCMP's are limited, specialists are limited. Within behavioral health, the regulations limit how many we can serve due to meeting multiple documentation requirements.
  a. If no, what are the gaps?

     State and Federal regulations and requirements really impacts the amount of services we can provide.

- Access to specialty care in rural/frontier parts of Colorado is a problem.
- Access to primary care, oral health and payment options significantly impacts care.
- Local pharmacies are being lost due to mail order requirements through insurances. This impacts rural/frontier level of care. Local pharmacies are able to do a more individualized services- such as bubble packing, assisting in delivery, lock boxes.
- Hospitals- we are losing a hospital in a rural community and we will be limited in how these individuals will receive care and emergency services.

  b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

     - Children dental care- adults are limited in access to oral health.
     - Dual eligible individuals are often struggling to access care and their doughnut hole coverage.
     - Income barriers
     - Fewer providers accepting Medicaid
     - Insurance coverage through ACC (catastrophe insurance, high co-pays, limited providers)

44. ACC Individuals and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

    a. What role should hospitals play in the next iteration of the ACC Program?

Hospitals need to have identified roles and address competing interests (ER Utilization)

- Incentivize dollars for diverting away from hospitals.
- Incentivize providers for expanded hours.
- Rural hospitals are collapsing in our small communities, such as St. Vincent Hospital in Leadville. Communities need to come together to develop urgent/emergent care models and identify transportation dilemmas to assist our members when appropriately in need of inpatient care.

b. What role should pharmacies play in the next iteration of the ACC Program? Local pharmacies are being squeezed out by larger mail order companies where insurance companies receive a percentage cut with the prescriptions. Local pharmacies have assisted our smaller communities by providing a valuable information resource and customer service for medications being delivered to patient's homes. They also have assisted with medication packaging to assist in patients adherence for taking medications.

Pharmacy information/data is important.

c. What role should specialists play in the next iteration of the ACC Program?

Specialty care needs to be more accessible in rural/frontier counties. The ACC program should provide incentives to specialists to provide care in these areas.

d. What role should home health play in the next iteration of the ACC Program?

Home health should be a central part of care planning. Hospitals should be required to work closely with home health agencies and identifying requirements. Home health care supports care coordination but it is a separate entity and often supports an individual within the community. The ability to access, even short term, should be streamlined for efficiency.

e. What role should hospice care play in the next iteration of the ACC Program?

Hospice care should be readily available to all patients in the ACC program.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

The role of SEP's and CCBs is very important. We should have partnerships in place to understand each entity's role and the expectations. Communication needs to occur across all system and data sharing that notes role person is playing.

g. What role should counties play in the next iteration of the ACC Program?

Develop community based programs to recruit/retain providers within community. Currently, on a local level we have long standing relationships with county entities including HB 14S1, Department of Human Services and Court programming.

h. What role should local public health agencies play in the next iteration of the ACC Program?

Public health agencies need to be an integral part of the referral resource for the ACC program. In addition, it would be important to have these programs align with the SIM grant and aligning with State for payment reform.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

Important organizations including the home health providers, Senior care services, nursing facilities, and alternative holistic services are all key and allowing communities to offer solutions of who should be at the table.

45. How can RCCOs help to support individuals and families in making and keeping appointments?

a. Transportation, child care payments, subsidies, telecare options for rural/frontier. Extended hours.

46. Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

No, this should be an option proposed by the respondents to the RFP. HCPF should be careful not to be too prescriptive in how the RFP requirements are developed. Leaving room for communities to offer solutions should be a key theme of the RPF.

47. **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement should be at the discretion of the RCCO and should not be prescribed by HCPF in the RFP.

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48. Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

    The RCCOs should have a role in coordinating oral health. Oral health need to be a part of overall health care and needs also be integrated.

49. Cultural competence among providers is important to ensure a Individual-centered, effective system that supports the health and well-being of individuals and families.

    a. What does cultural competence mean to you?

    Understanding your community and the individuals that make up your community or geographic area. For example, our community has a high level of poverty, low literacy rates, and limited employment opportunities.

    b. What RCCO requirements would ensure cultural competency?

    We are always addressing the unique qualities of our communities, that varies even between communities, families, and individuals. You can't lay out a plan that addresses this as it is beyond race, religion, or gender. This is the importance of knowing your community.

    c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Individuals/families including those with low health literacy?

    The skills must be driven by the values of the organization, the community, and meeting the needs of the population we are serving.

    Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. Getting individuals inside our doors or letting us in there door can be a problem. Access is a huge issue.

    What RCCO requirements would help address these and reduce inequality in health outcomes? I don't know if a RCCO can address this.

50. 5hould the next RFP allow for preferred networks for specialty, facility, or ancillary care?

    Availability and access becomes an issue.

51. Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

    There needs to be a major plan to provide incentives for individuals to not utilize the emergency room for routine care.

52. Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53. **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☐	☒	☐	☐
Assistance with efficiency-enhancing activities	☐	☒	☐	☐
Provide web-based resources and directories	☒	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☒	☐	☐
Provide clinical screening tools	☐	☒	☐	☐
Provide health and functioning questionnaires	☐	☒	☐	☐
Provide chronic care templates	☒	☐	☐	☐
Provide registries	☒	☐	☐	☐
Offer individual reminders	☒	☐	☐	☐
Offer individual self-management tools	☐	☒	☐	☐
Offer educational materials about specific conditions	☐	☒	☐	☐
Supply behavioral health surveys	☐	☒	☐	☐
Supply other self-screening tools	☐	☒	☐	☐
Administer behavioral health surveys	☒	☐	☐	☐
Administer other self-screening tools	☒	☐	☐	☐
Prepare individual action plans	☐	☒	☐	☐
Provide training on providing culturally-competent care	☐	☒	☐	☐
Provide training to supporting staff	☐	☒	☐	☐
Provide training on motivational interviewing	☐	☒	☐	☐
Provide tools and software for phone call and appointment tracking	☒	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☐	☒	☐	☐
Provide standing pharmacy order templates	☒	☐	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☐
Provide directory of other resources	☒	☐	☐	☐
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☒	☐	☐

Others	

54. If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55. What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

    - Let us bid and offer solutions that may work within our communities.

56. What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a individual's medical home?

    Rates provided but with clear understanding of responsibilities.

57. Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58. Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59. Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

    Allowing the RCCO to have more financial control over how the distribute the financial incentives would allow us to meet our individual region/community needs more effectively.

60. If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

    N/A

61. Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

    The fee for service level of reimbursement does not promote cost saving but promotes service delivery.

62. The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

    N/A

63. What role – if any – should the RCCOs play in the distribution of payments to providers?

    RCCO's should play a more significant role in distribution of payments to providers.

64. Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65. What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of individuals and providers, and health outcomes?

66. **Measuring Individual experience.** Please complete the table below to indicate how the Department should measure Individual/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	All of these should be options for measuring quality.
SF-12 Health Survey	☐	☒	No- this is no longer a relevant form being utilized.
Other types of individual interviews / surveys	☒	☐	PHQ9
Patient Activation Measure	☒	☐	
Focus groups	☐	☒	Limited attendance and feedback.
Other	Depends on population health needs. Currently- would need to switch out where we require so many screens and tools- what would give.		

67. Knowing that, at this time, the Department only has claims data, how should population health be measured?

- We need to be able to screen individuals and account for the time and linkage we do as a result.

68. How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

- Through data dashboards and public access.

69. **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7 at most	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐

51+	☐
None	☐

70. What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☒
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71. Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

- It should be a combination. Overall KPIs should address population health but allow for local indictors to address community needs as well identifying social determinants and how to impact this area.

72. Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

- Overall improvements.

73. Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

N/A

74. **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

N/A

75. For potential Offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

    Fixed costs include having care coordinators available emergently to assist in tracking and follow up for urgent/emergent individual needs, including monitoring emergency care and follow up. In addition, the required care plans and service coordination plans that must be completed every 6 months face to face. Transportation access to assist individuals in getting to the facilities, medical appts. Or to our location.

76. For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

    We are evaluated on 34 measures specific to this, but we also participate in multiple external and internal audits, peer reviews, coding audits, and Medicare audits. All of the services documented under the care coordination may be part of these additional audits as well. We also have multiple patient screens and key performance indicators we must meet.

Health Information Technology (HIT)

77. **Types of communication.** For individuals with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☒
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☐	☒
Smartphone app	☐	☒
Other: I would use if they could accept it.		

78. **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☐	☒

Care transitions alerts	☐	☒
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☒	☐
Practice assessment tools	☒	☐
Practice management tools (scheduling, billing)	☒	☐
Individual web portal for communicating care plan, services, benefit enrollment	☐	☒
Patient education/wellness tools	☐	☒
Provider/case manager directory	☐	☒
Shared decision-making tools	☒	☐
Telemedicine software	☒	☐
Other:	☐	☐
Other:	☐	☐

79. **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-S, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☒	☐
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☒	☐
Electronic Health Records (EHRs)	☐	☐	☐	☒	☐
Practice assessment tools	☐	☒	☐	☐	☐
Health risk assessment software	☐	☐	☒	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☒	☐	☐
Individual web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☒
Patient education wellness tools	☐	☐	☒	☐	☐
Provider/case manager directory	☐	☐	☒	☐	☐
Shared decision-making tools	☐	☒	☐	☐	☐
Telemedicine	☐	☐	☐	☒	☐
Other:	☐	☐	☐	☐	☐

80. What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

    Staff having access and being able to utilize information.

81. How can Health Information Technology support Behavioral Health Integration?

    HIT is key moving forward and sharing data in real time will benefit the client, reduce duplication in services, testing, or clients recall regarding services, tests etc...
    One significant challenge is finding an Electronic Health Record that meets the needs of behavioral health and medical/specialty care. We are in continuous discussions with major companies advocating for a record to meet our complex needs for true integration, including a patient portal.

82. In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

    Yes there should be a shared resource- and shared with all providers not on one side of care. It should include cost of care, duplication in care, and health outcomes.

83. Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

    Real time data is what is helpful- who is in the ER today or last night is key. Appointments, tests, schedules for follow up would help us reduce time trying to track all levels of care and ensuring needs are met. Care coordination usually occurs after the fact, often much later, and is ineffective.

84. Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

    This task should be the responsibility of the RCCO and the providers. The tool could look at the overall use of care by a population and identify duplicate and inappropriate care so that these trends can be addressed with the providers within the RCCO and further education or explanation can be provided. If we identify a way to provide incentives for appropriate levels of care versus inefficiencies.

85. Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

    Any directory that is maintained should identify specialties and should be up to date and maintained.

86. How can the RCCOs support providers' access to actionable and timely clinical data?

    Any access for the providers would be an improvement of the make shift data we currently receive via multiple reports that do not match each other and are relying on old data and attribution.

87. What are the HIT solutions that would benefit individuals, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

A joint EHR that also brings in outside data and works with CORHIO or QHN.

88. What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, individuals/families, or for others.

Technical assistance should include a shared database so we can identify readily who is involved with multiple care providers, agencies, and requiring additional services or coordination versus the 12-15 phone calls to identify who is working with which agency or individual.

89. What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

They are key in making this successful.

90. Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 060

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Bob Ward
Location: Arapahoe, Douglas County, City of Aurora

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Developmental Pathways, Inc.
Location: Englewood, CO
X Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
X Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☐ Yes
X No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Our organization share mutual clients with the RCCO and has been engaged in data sharing and discussions on how to work to together to achieve better outcomes for clients.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Community Centered Board providing Medicaid Waiver Case Management Services and Medicaid waiver services to the IDD population of Arapahoe, and Douglas counties and the City of Aurora.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
X Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

We believe there is great opportunity for cooperation and/or delegation with our RCCO for the provision of care coordination services for individuals in IDD waiver services.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

The continued outreach to the medical neighborhood.

2) What is not working well in the ACC Program?

A lack of clarity on the ultimate role of the ACC and the future of Medicaid services in Colorado.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

The BHO system is generally not accessible to the IDD population resulting in significant personal hardship for individuals and families and tremendous inefficiencies in the provision of health care.

Strict and unreasonable adherence to the covered diagnosis list; a long standing culture of belief in the BHO system to exclude IDD clients; and a lack of expertise in the provider network all effect the lack of services and access for IDD individuals.

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

The issues above need to be addressed. Designated points of contact for IDD individuals would be a start.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	X	☐	**To narrowly interpreted for IDD individuals.**
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	X	☐	**IDD individuals cannot access**
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	X	☐	**Lack of expertise in the IDD field.**
State/Federal rules or reporting requirements	X	☐	**Programs and funding sources are too siloed. Overall lack of funding in all systems**
Technical resources / data sharing	X	☐	**See above**
Training	X	☐	**See above**

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Others	Please type your response here.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

Care coordination should be flexible and individualized. Service definitions for reimbursable care coordination and services should also be flexible to allow creative problem solving and reduce overall bureaucratic inefficiencies.

b. How should RCCOs prioritize who receives care coordination first?

c. How should RCCOs identify clients and families who need care coordination?

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

Long term care coordination should be integrated with physical and behavioral health. Such coordination should be delegated at the most effective level. In the IDD system the most significant barrier is behavioral health.

In looking to the future, the emphasis should be on leveraging successful existing models rather than dismantling and rebuilding. There is a significant concern that the current IDD system expertise and experience will be sacrificed to overall system uniformity.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

An individually assigned care coordinator with the adequate time and resources to craft an individualized plan to address a person's desires and needs.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

Care coordination in the IDD system is very successful. There is opportunity to expand such coordination in the physical and behavioral health areas.

What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

See above.

b. How can the ACC avoid duplicating or disrupting current care coordination relationships?

The ACC should cooperate with or delegate too existing care coordination in the IDD system to avoid duplication or disruption to individual services and reduce complexity in the system. The future ACC contract structure should allow ACC's flexibility to build upon existing systems including but not limited to contracting or subcontracting with existing providers.

c. What are the gaps in care coordination across the continuum of care?

Substantial gaps remain in the behavioral health area.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	
Health literacy	☐	☐	☐	
Housing	☐	☐	☐	

Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	
Transportation	☐	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	**Coordinate care?** Yes	No	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	

Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	**Community Centered Boards (CCBs) have been doing successful care coordination for IDD individuals in their communities for many years.**		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	

Clients with a disability	X	☐	Individuals with IDD present unique challenges and vulnerabilities.
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19)

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

To achieve meaningful care coordination, especially with complex populations, funding must be adequate and recognize the skill set required for successful care coordination. In addition, funding should be flexible and not overly rigid in definition or application.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

Yes

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

No – allow the contracting entities to manage.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐

201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

Keep the metrics simple and attainable.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

CCB have years of experience in care coordination/case management and in networking within their communities. Substantial expertise has also been developed relative to the IDD population in the state and community resources. The ACC program should look to leverage CCB assets in an integrated health care model. The state should encourage cooperation and provide flexibility for greater CCB/ACC leveraging of resources via informal and formal mechanisms.

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 061

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Cynthia T Weinmann
Location: White Plains, Westchester County, New York

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: APS Healthcare
Location: White Plains, Westchester County, New York
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Care Management Vendor

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☒ 3-4 years ??

How have you been involved in the ACC program and what interaction have you had with RCCOs:

APS is the current Colorado Medicaid UM Program vendor, and interact with RCCOs as part of this role through our administration of the Client Over-Utilization Program (COUP).

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

APS provides UM/CM/DM services to State Medicaid agencies in California, Colorado, Georgia, Maine, Oregon, Vermont, and West Virginia. This includes utilization review, care coordination, technical assistance to providers, actionable analyses of system and provider performance on access, quality of care, and cost patterns and trends.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely need to unclick this one
☒ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

2) **What is not working well in the ACC Program?**

Inconsistency between RCCOs leads to variability in performance, and presents barriers to performance evaluation and improvement. In our experience, regional Care Coordination Organizations (CCOs) operate most effectively and efficiently when there is a strong component of systems, tools, technical assistance, and metrics that are common to all organizations, including the following elements:

- An integrated and comprehensive person-centered database to support analytics, reporting, and care coordination
- Stratification of the population to identify and prioritize care coordination interventions
- Functional assessments of high-risk, high-cost Clients that are independently conducted to avoid conflict of interest with the outcomes of the assessments. These assessments identify care coordination and care management needs to prioritize intervention strategies, including if needed, a lock-in program such as the Department's Client Over-utilization Program (COUP)
- System tools including outreach queues, care/service plans, provider rosters, and gaps in care report
- Performance metrics that can be used to equitably evaluate RCCO performance
- Technical assistance to RCCOs and providers to use common tools

Without these common infrastructure elements, significant variation between RCCOs prevents evaluation of RCCO performance, and just as importantly, interferes with sharing lessons learned and best practices across RCCOs. Further, smaller RCCOs may not be able to implement sophisticated care tools and systems. Providing basic population health management tools can create a level baseline among RCCOs, and allows the Department greater choice among organizations. This opportunity is especially important if the Department intends to select more than one RCCO per region.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Organizations, agencies, and the State are committed to the delivery of integrated care, and have made great strides to increase the integration of behavioral health (including substance use services) into primary care. We suggest several opportunities to evolve integrated healthcare for Medicaid Clients in Colorado:

- Move to eliminate the carve-out of behavioral health services. By definition, "carved out" services are not integrated into a unified medical and behavioral health delivery system. Separate networks, billing and management systems, and administrative infrastructure add cost and contribute to disconnected care.

- Develop a bi-directional model to integrate primary care services into community-based behavioral health to accommodate individuals with serious mental illness. Literature suggests these individuals experience additional barriers to primary care, and may prefer receiving services through a specialty provider.

- Continue payment reform that supports integration, including, for example:

    - Allowing billing of primary care and behavioral health services to the same person on the same day

    - Develop and administer benefit packages that encourage "bundled" medical and behavioral health services, such as services for diabetes and schizophrenia or behavioral health services and smoking cessation.

- Develop a Service Plan model for Clients with co-occurring conditions that provides a framework for integrated service delivery, with defined roles for the Client and Integrated Service Team

    - The Medicare Model of Care for Dual eligible and the Medicare/Medicaid demonstrations suggests such a framework

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☒	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☒	☐	PCMP financing in general needs to should support the need on the part of physicians and office staff to spend time with individuals who present with co-occurring conditions.
Per-member per-month amount	☒	☐	Current PMPMs for RCCOs (stated in the Q&A as between $8.43 and $9.00) seem inadequate to address the intensive and potentially long-term services required for individuals with serious mental illness and substance use disorders
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☒	☐	These laws limit sharing of information that promotes integration
Professional / cultural divisions	☒	☐	Basic understanding of the purpose of services differs greatly between medical and behavioral health – e.g., curing vs recovery, medication vs therapy, etc. Additionally, behavioral health providers may be concerned by the apparent shift of service delivery from specialty settings to primary care settings as the most appropriate service setting for Clients with serious mental illness; primary care providers may be similarly concerned at the presence of individuals with

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

			behavioral health and/or substance use disorders in their primary care settings. Cultural and professional issues can be resolved by training and practice; bi-directional integration helps to address concerns about the setting of care.
RCCO or BHO contracts	☒	☐	Please see our comments above concerning a carved out behavioral health system.
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☒	☐	Data integration is a foundational tool for service integration and care coordination, and technical resources should include risk adjustment that factors in the presence of chronic illness; behavioral health issues; and substance use disorders so that RCCOs can identify appropriate staffing models (e.g., a combination of behavioral health professionals and medical professionals for care coordination) and prioritize Clients appropriately. Additionally, variations in practice among RCCOs contribute to a lack of consistency between CCOs, and may limit the Department's ability to evaluate the full impact of RCCO interventions. One way to address this issue is to develop baseline requirements; another is to implement processes through a statewide vendor. For example, the SDAC can provide risk-adjusted financial and other risk-adjusted impact reports.
Training	☒	☐	A serious need is training for "first responders" (emergency medical personnel, police, school personnel, and clergy, for example) to understand and recognize symptoms of behavioral health crisis and be able to respond appropriately.
Others	Care coordination tools that support integration, through development of an integrated Service Plan and information sharing among an Integrated Service Team, including the Client.		

9) **What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?**

- A complement of relevant personnel, including primary care, behavioral health, and substance use disorder professionals to provide parity in access to medical and behavioral health services
- The ability to offer expanded hours to adults with behavioral health issues and/or separate waiting areas. For example, the Commonwealth of Puerto Rico does not allow adults and children to use the same waiting room to receive behavioral health services.

10) **Please share any other general advice or suggestions you may have about behavioral health integration.**

Consider allowing behavioral health providers/clinics/systems to serve as RCCOs with integrated primary care into behavioral health settings.

Care Coordination

11) **Care coordination is an important part of the ACC Program.**

a. What is the best definition of care coordination?

As defined in a publication from the Agency for Healthcare Research and Quality, and widely adopted by other organizations such as Dr. Ed Wagner and colleagues at the McColl Institute for Healthcare Innovation:

Care coordination is 'the deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services." [3]

We understand "participants" to include medical, behavioral health, and home and community-based providers and other members of an integrated service team, including pharmacists, for example, as well as the individual whose care is being coordinated.

b. **How should RCCOs prioritize who receives care coordination first?**

There are very sound metrics that quantify indicators of "uncoordinated care" that can be applied at the individual level, such as admissions for ambulatory care-sensitive conditions, emergent and non-emergent visits to the emergency department, lack of engagement with a usual source of care, etc. Additionally, evidence suggests that multiple and/or co-occurring conditions increase the likelihood that individuals will experience uncoordinated care, especially in combination with indicators such as those mentioned here. These metrics, together with diagnostic information, can be applied to claims retrospectively and assessment data prospectively to prioritize individuals for care coordination.

An important point is that this approach should be consistent from RCCO to RCCO since variation in selection of metrics, application to the population, ability to produce analytics and reports will undermine the Department's ability to evaluate the program as a whole and usefully compare RCCOs to state results and to each other.

c. **How should RCCOs identify clients and families who need care coordination?**

By using indicators such as those discussed in item 11)b to quantify the extent to which Clients and families have characteristics of uncoordinated care.

d. **How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?**

[3] McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; June 2007. [link]

We strongly recommend data integration that brings together assessments, clinical, claims, and home-and-community-based services data to create a person-centered database that is centralized and consistent between RCCO regions. This information can be compiled automatically through feeds from RCCO and provider systems as well as from the MMIS. The person-centered data system can then be used to calculate indicators of uncoordinated care at the individual level as well as acuity and risk factors. When shared with RCCOs and providers, the data can also form the basis for integrated service plans.

12) **What services should be coordinated and are there services that should not be a part of care coordination?**

For individuals who need care coordination, such as Clients with multiple co-occurring conditions or individuals who need access to home and community-based services (HCBS) to avoid institutionalization, most services should be part of an integrated care plan and coordinated among providers. These services would include, for example, medical, behavioral health, HCBS, meals, transportation, and medication; they could also include supported employment and housing for certain individuals, as well as linkages to community-based resources such as WIC, assistance with utilities, food pantries, etc.

13) **What pieces of information are most important to have about someone in order to know what care coordination he or she needs?**

Functional status, living/support resources, and diagnoses are key pieces of information.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

A very special situation is that the Statewide UM Contractor provides limited care coordination for individuals who are enrolled in the Client Over-utilization Program and are not affiliated with a RCCO. The coordination is focused on changing Client behaviors that are linked to over-utilization, and services coordinated are limited to specific primary care, facility, and pharmacy providers.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

Consumer direction for care coordination would enable clients to select among qualified care coordinators depending on their needs and existing relationships.

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☒	Providing specialized, trauma-informed services through medical and behavioral health providers
Affordability (assistance with prescriptions or co-pays)	☒	☐	☐	
Daycare / childcare	☒	☐	☐	
Economic stability & employment	☒	☐	☒	For individuals with supported employment, some oversight of the supported employment provider should be a RCCO role
Education	☒	☐	☒	Related to school-based behavioral health and primary care, RCCOs should include these entities in their networks
Environment	☒	☐	☒	Relative to environmental modifications that may be required for certain Clients, to have oversight of the provider network and authorization for the service
Food access / nutrition	☒	☐	☒	For HCBS services, RCCOs should have the ability to oversee and authorize services as part of a comprehensive service plan
Health literacy	☒	☐	☒	RCCOs should be aware of health literacy issues in their populations, and be able to arrange for programming to improve it.
Housing	☒	☐	☒	For HCBS services, RCCOs should have the ability to oversee and authorize services as part of a comprehensive service plan
Language or translation services	☒	☐	☒	RCCOs should be able to know if providers are arranging for needed language or translation services and facilitate access for their enrolled Clients
Literacy	☒	☐	☐	
Transportation	☒	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	Field-based and telephonic coordination of more intensive services related to their practice specialty as part of a multi-disciplinary team
Certified Addiction Councilors	☒	☐	Field-based and telephonic coordination of substance use disorder services as part of a multi-disciplinary team
Certified Nurse Midwives	☒	☐	Office and practice-based coordination of pregnancy services as part of a multi-disciplinary team
Community Health Workers	☒	☐	Access to HCBS, again as part of a multi-disciplinary team
Generalists (BA/BS/MA/MS)	☒	☐	Generalists can coordinate non-clinical services as part of a multi-disciplinary team
Health Coaches	☒	☐	Delivery and coordination of health education and self-management skill training
Licensed Clinical Social Workers	☒	☐	Field-based and telephonic care coordination of HCBS services and clinical behavioral health, medical, and substance use disorder (SUD) services
Licensed Marriage and Family Therapist	☒	☐	Field-based and telephonic care coordination of HCBS services and clinical behavioral health and SUD services
Licensed Mental Health Counselors	☒	☐	Field-based and telephonic care coordination of HCBS services and clinical behavioral health and SUD services
Licensed Professional Counselor	☒	☐	Field-based and telephonic care coordination of HCBS services and clinical behavioral health and SUD services
Masters of Public Health	☒	☐	MPHs can coordinate non-clinical services as part of a multi-disciplinary team and may also be able to deliver health education if that was part of their MPH
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	Office- and facility-based coordination of medical services
Nurse Practitioners	☒	☐	Field-based and telephonic coordination of more intensive services related to their practice specialty as part of a multi-disciplinary team
Patient Navigators	☒	☐	Facilitation of access to services and assistance with resolving barriers to care

Peer Advocates	☒	☐	Facilitation of access to services and assistance with resolving barriers to care, coordinate and attend office visits and other services as needed
Promotoras	☒	☐	Facilitation of access to services and assistance with resolving barriers to care, coordinate and attend office visits and other services as needed
Psychiatrists	☒	☐	Office- and facility-based coordination of medical services, with an emphasis of medication reconciliation for psychotropic medications
Psychologists	☒	☐	Field-based and telephonic care coordination of clinical behavioral health and SUD services, especially for individuals with serious mental illness and co-occurring conditions (assumes PhD)
Registered Nurses	☒	☐	Field-based and telephonic coordination of services as part of a multi-disciplinary team
Social Workers	☒	☐	Field-based and telephonic coordination of services as part of a multi-disciplinary team
Wraparound facilitators	☒	☐	Facilitation of integrated care plan and assistance with resolving barriers to care, coordinate office visits and other services as needed
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☐	Access to NICU specialists post-discharge for low birth-weight babies
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☒	☐	Include coordination of services for the family as well as access to pediatric specialties and subspecialties
Children involved in the foster care system	☒	☐	Focus on continuity of care coordination across foster families as well as access to related social services
Children with a chronic illness	☒	☐	Specialty/pharmacy coordination and access to behavioral health supports for child and family; coordination of home care and other community-based services; coordination with school (e.g., IEP)

Children with a serious emotional disturbance	☒	☐	Specialty/pharmacy coordination and access to behavioral health supports for child and family; coordination of home care and other community-based services; coordination with school (e.g., IEP)
Children with medical complexity	☒	☐	Specialty/pharmacy coordination and access to behavioral health supports for child and family; coordination of home care and other community-based services; coordination with school (e.g., IEP)
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	Specialty/pharmacy coordination and access to behavioral health supports for child and family, including coordination that is trauma-informed and familiar with the juvenile justice system; coordination of home care and other community-based services; coordination with school (e.g., IEP)
Transition-age adolescents	☒	☐	Should include Peer Supports to facilitate transition from pediatric to adult providers as well as support to transition to more limited benefit package
Parents and families	☐	☒	
Pregnant women	☐	☒	
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☒	☐	Include coordination of services for the family as well as access to social services
Adults with a chronic illness	☒	☐	Specialty/pharmacy coordination and access to behavioral health supports for Client and family
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	Specialty/pharmacy coordination and access to behavioral health supports for Client and family
Clients involved in the criminal justice system	☒	☐	Coordination of legal services and medical/behavioral health services to promote access to timely care and prevent inappropriate incarcerations
Clients with a disability	☒	☐	Coordination of HCBS with medical/behavioral
Clients in a nursing facility	☒	☐	Coordination of primary care services to prevent avoidable admissions for conditions such as dehydration, for example

Elderly clients	☐	☒	
Frail elderly clients	☒	☐	Coordination of primary care services to prevent avoidable admissions for conditions such as dehydration, for example. Also, coordination of HCBS such as home modifications, Personal emergency response systems, etc.
Clients in palliative care	☒	☐	Coordination of support for Client and families
Other populations, please comment:			

18) **How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?**

Representatives of the child-serving agencies, such as Case Workers, should be considered part of the Integrated Care Team and be involved with the Integrated Service Plan.

19) **How should care coordination be evaluated? How should its outcomes be measured?**

Applying the Triple Aim – cost, health status, and Client experience – helps to define how care coordination can be evaluated:

- Cost: tracking utilization of uncoordinated care (avoidable admissions, readmissions, and emergency room visits, for example) per person, adjusted for acuity
- Status: Including community tenure, functional status, and ability to engage in community activities, including school and work. Individual status can also be measured by tools such as the Patient Activation Measure (PAM).
- Client experience – using CAHPS or another survey tool

Again, apply these measures and activities consistently to individual RCCOs helps to ensure that the evaluation can be used to improve care coordination and hold RCCOs accountable in an equitable way.

20) **Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.**

a. What is the PMPM cost for providing care coordination services?

b. **Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?**

An escalation factor should be applied depending on several factors:

- Individual acuity – how intensive is the individual's coordination needs?

- Population acuity – how intensive/acute is the RCCO's overall population?

Please note – for this factor to avoid "gaming," it is important that Clients receive what CMS calls a "conflict-free assessment," that is, an assessment that is conducted by a party that is free from any conflict of interest regarding the results of the assessment

21) **Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?**

No. RCCOs should be able to vary the workload according to the location, Client acuity, type of condition(s), etc. The requirement should be accountability to expected outcomes, regardless of the model used.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) **How should care coordination outcomes be evaluated by the Department? Which metrics are most important?**

We use claims-based indicators of uncoordinated care to evaluate outcomes:

- Admissions per 1,000 Clients (lower is generally better)
- Admissions for ambulatory care-sensitive conditions (lower is better)
- Readmission rate (lower is better)
- Visits per 1,000 Clients to the Emergency Room (lower is better)
- Emergency room visits for non-emergent care per 1,000 Clients (lower is better)
- Engagement with a usual source of primary care, measured by frequency of visits to PCP and/or use of non-institutional providers for primary care (higher is better)

The benefit of these measures is that they can be efficiently applied to the total population on a monthly, quarterly, and annual basis to establish baselines and then track improvements. They are also helpful in identifying best practices among high performing providers, groups, and RCCOs, and share these best practices across the system to improve performance at the statewide level.

Additionally, tools such as the Patient Activation Measure (PAM) published by InsigniaHealth provide quantitative results on engagement of Clients with their health and healthcare, and development of self-management skills.

23) **Please share any other general advice or suggestions you have about care coordination in the ACC.**

We suggest that the Department consider a statewide vendor contracted by the RCCOs that provides comprehensive and standardized support to the RCCOs and their providers, and integrated with the statewide UM functions. Responsibilities of this vendor should include:

- Electronic data interchange with RCCOs, providers, CORHIO, QHN, and MMIS to provide a comprehensive, person-centered data system including medical, behavioral, HCBS, and pharmacy claims as well as clinical information such as lab values
- Identification and Stratification processes to continuously identify high-risk, high-cost Clients and prioritize them for RCCO and provider interventions
- Conflict-free assessment of high-risk, high-cost individuals to support comprehensive care planning
- A web-based and standardized care coordination tool that automates service plans for each Client, and generates care planning data and reports such as gaps in care reports and provider registries. The care coordination tool should be accessible to RCCO and Provider for interactive use as desired and interfaced with RCCO and provider systems to avoid duplication of systems and level of effort at the local level
- Assistance with integration and care coordination to support RCCOs and providers for the highest cost/risk clients who may present difficulties for RCCOs
- Specialized initiatives, such as emergency department diversion
- Nurse Advice Line and crisis line

Additionally, Care coordination activities should be team-based, with physicians, nurses, social workers, peer facilitators, pharmacists, and others as part of the Integrated Care Team. Care Coordinators should be part of this team and have the ability to interact with all other members. Care coordination includes a combination of field-based, face-to-face and telephonic support, and should be based on a comprehensive individual service plan that integrates services. The service plan should be based on a conflict-free assessment that documents Client needs and status.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Process and outcome measures should be standardized across RCCOs.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Documentation of existing relationships or letters of intent/memorandum of understanding to work with the prospective RCCO.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This only makes sense if there is more than one RCCO per region.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

Yes, behavioral health should be integrated into the RCCO, so the regional map would be the same.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) **Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?**

Having more than one RCCO per region, promotes choice, just as many states have more than one managed care organization per region for that same reason. Currently, Clients that are unhappy with their RCCO have the option of leaving the program – that is, withdrawing from care coordination. If there were more than one RCCO, Clients would have a choice and RCCOs would have incentives for good performance. This approach might then be more successful at promoting good performance than additional funding.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) **What role should RCCOs play in attributing clients to their respective PCMPs?**

None. This attribution should be conducted by an independent statewide vendor.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

There are very good opportunities to collaborate on public health initiatives – improving rates for preventive services, regional and/or seasonal campaigns for vaccinations, wellness initiatives, etc.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

Extensive collaboration around the children with special needs, children in foster care, and children in the juvenile justice system, including integrating DHS Case Managers into the integrated care team.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

Collaboration to facilitate the transition of individuals between Medicaid and health exchange eligibility.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Collaboration and coordination around regulatory and licensing requirements.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☒
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☒
Provide practice-specific data reports	☒	☐	☐	☒
Provide clinical care guidelines and best practices.	☒	☐	☐	☒
Provide clinical screening tools	☒	☐	☐	☒
Provide health and functioning questionnaires	☒	☐	☐	☒
Provide chronic care templates	☒	☐	☐	☒
Provide registries	☒	☐	☐	☒
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☒	☐	☐	☒
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☒
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☒	☐	☐	☒
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) **Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?**

No. Providers do not have access to timely data about Client health status, services, and utilization to prioritize patients and manage populations efficiently. Additionally, other system components that relate to value are not under the control of providers yet would affect their performance.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	
SF-12 Health Survey	☒	☐	Integrated into care coordination tool
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☒	☐	For high-risk, high cost Clients to evaluate their baseline engagement ability and track progress of interventions
Focus groups	☐	☐	
Other	Please type your response here. Functional and risk assessments		

67) **Knowing that, at this time, the Department only has claims data, how should population health be measured?**

Two basic methods:

1) Access to and utilization of specific primary and preventive care services
2) Uncoordinated care indicators

68) **How should quality and performance data be reported to the RCCOs, PCMPs, and the public?**

Performance measures should be selected based on relevance and feasibility, adjusted to reflect population acuity and other factors accurately, and reported publicly through user-friendly report cards.

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐

51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) **Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?**

Both. Larger RCCOs are better able to afford to fund infrastructure and staffing, and might therefore perform better on measures tied to national standards. For these RCCOs, a ceiling effect would disincentive them from making large improvements. Smaller RCCOs might not be able to meet national standards but could improve performance over their own baselines. Using both approaches helps to ensure that RCCOs have incentives to achieve standards, and continue incrementally improving.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential 27fferors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☒	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☒	☐
Practice assessment tools	☒	☐
Practice management tools (scheduling, billing)	☐	☐

Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☒	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other: Gaps in Care reporting, provider registries, health status assessments	☒	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-S, where 1 are those items least-likely to be used, and S are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☒	☐
Practice assessment tools	☐	☐	☒	☐	☐
Health risk assessment software	☐	☐	☐	☐	☒
Practice management tools (scheduling, billing)	☐	☐	☒	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☒	☐
Patient education wellness tools	☐	☐	☐	☒	☐
Provider/case manager directory	☐	☐	☐	☒	☐
Shared decision-making tools	☐	☐	☐	☒	☐
Telemedicine	☐	☐	☒	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

81) **How can Health Information Technology support Behavioral Health Integration?**

Through data integration as described in 11)d – the development of a comprehensive and integrated person-centered database that includes claims, assessments, eligibility, and other information about Clients. This integrated database can then support the development of integrated service plans to support the Client and an integrated service team.

82) **In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.**

Yes. There should be a statewide data/analytic and care management system that integrates eligibility, claims, and health status to create a model, automated service plan that is accessible to RCCOs and providers. Information should be organized by Client, include risk/acuity assessment, service plans, and care coordination tools. This resource should be web-based and accessible to stakeholders through a secure web portal.

As a method to promote consistency and appropriate standardization across RCCOs, this system would then incorporate needed tools and exchange data with RCCO, state, and provider systems.

83) **Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.**

Yes. This tool should be integrated with the data and analytics tool to allow Care Coordinators to facilitate management of the Integrated Service Plan across providers and systems, including non-clinical services. The Care Management tool should include:

- Auto-generated Service Plan based on data integration and risk modeling that can be modified and maintained by the Integrated Service Team (IST).
- Background of utilization and services, including medical, behavioral healthcare, dental, pharmacy, and HCBS services
- Assessment tools and results
- Integrated risk adjustment/status tools such as Chronic Illness and Disability Payment System (CDPS) and the Patient Activation Measure (PAM)
- Tracking and communication tools to monitor the service plan and communicate between members of the IST.
- Ability to generate provider registries and gaps in care reports, as well as uncoordinated care indicator reports

84) **Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.**

Please note, we define population health management (PHM) as the process of strategically and proactively managing clinical and financial opportunities to improve health outcomes, strengthen patient engagement with their providers, and reduce avoidable costs of care. A population health management tool should be a system, combining features of data management and analysis and care coordination tools to provide comprehensive support for program operation. Criteria for a PHM tool therefore include:

- **Identification and Stratification**

The system/tool should be able to accommodate custom definitions of the target population, and be able to stratify them according to utilization, status, and risk characteristics. The tool should also allow updates and changes to the definitions and stratification to align with program evolution.

- **Evidence Based Care Plan**
  An evidence-based care plan should be developed by the system as a modifiable template based on applying identification and stratification algorithms. This "model" care plan can then be managed by members of the care team as a continuous road map for integrated, comprehensive care.

- **Coordination and Engagement**
  Additional important criteria for the PHM tool is to help the care team prioritize interventions, coordinate care, and engage the Client and each other. How the tool would support these activities is by continuously refreshing the individual Client's record with new UM and other data, creating outreach listings and provider registries (for example), and providing the means to document and update the Client's care plan to reflect these activities.

- **Analytics and Reporting**
  Information that the system generates includes, for example:

  - Key Performance Indicators (KPIs) selected by the program, by population group, RCCO, provider type, individual provider, Client demographics, etc.
  - Gaps in care such as health and wellness services
  - Indicators of uncoordinated care
  - Provider registries and profiles
  - Client risk and utilization reporting, including stratifying Clients as candidates for the Client Over Utilization Program

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

90) **Please share any information, advice, and suggestions you have about health information technology in the ACC Program.**

In this response, we suggested several ways for the Department to promote consistency of systems, tools, and other factors between RCCOs to support their ability to deliver care coordination interventions and the ability of the Department to evaluate RCCO performance against national standards such as HEDIS as well as compare RCCOs equitably to each other.

APS Healthcare provides such a common systematic approach, and welcomes the opportunity to provide a live web-based demonstration of this system so that the Department can see an example of how tools and systems can support RCCOs and providers. Our contact information is included with submission of this response.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 062

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

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November 24, 2014

Kevin Dunlevy-Wilson
Department of Health Care Policy and Financing
Accountable Care Collaborative Strategy Unit
1570 Grant Street

RE: Request for Information (RFI UHAA 2015000017) Accountable Care Collaborative

Dear Mr. Dunlevy-Wilson:

Deloitte Consulting LLP (Deloitte), a professional services firm, is pleased to submit a response to the RFI related to Colorado's Accountable Care Collaborative (ACC) initiative.

As requested, we included a response to the basic information about the respondent template. While the current timing of this RFI did not allow us to respond to as many topical areas as we would have preferred, we have provided some comments related to the Payment Structure and Quality Monitoring section. In our response, Deloitte incorporated information gained through supporting clients across the health care market with similar efforts. Our client support includes working with both commercial accountable care organizations (ACOs) as well as states implementing ACO and other value based care initiatives into their Medicaid programs. We have included information from a diverse background of resources including, clinicians, data specialists, actuaries, health program professionals, and information system specialists.

We are excited to be able to provide insight to Colorado and hope our submission provides helpful information for this important initiative. Given our national experience with various Accountable Care Organization initiatives we would like to extend an offer to the Department to help further shape the direction for the design of various components of the ACC program, such as the Payment Structure and Quality Monitoring, Behavioral Integration and Health Information Technology. Please let us know a good time to discuss potential next steps.

Should you have any questions, please feel free to contact me at 612-659-2595 or tsteiner@deloitte.com.

Sincerely,

Deloitte Consulting LLP

Thomas J. Steiner

By:
Thomas J. Steiner, ASA, MAAA

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Tom Steiner
Location: Minneapolis, Hennepin County, Minnesota

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Deloitte Consulting LLP (Deloitte)
Location: Minneapolis, MN
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☒ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☐ Yes
☒ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
We have no direct involvement with the ACC program at this time.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Please see the following page for a description of our involvement with Medicaid programs across the nation.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes

☐ Will not seek to participate
☒ N/A

Deloitte works with the State of Colorado on a variety of initiatives; we understand the value of a good working relationship. We are willing to invest in this initiative to further our relationship and position Deloitte to work with you to further implement various components of the ACC initiative.

Response to Payment Structure and Quality Monitoring

As mentioned in the introductory letter, we have provided some comments related to the Payment Structure and Quality Monitoring section. While the ACC is a leading-edge state Medicaid program, we trust that our national experience with ACO programs is helpful in your goal to make bolder, more-comprehensive changes to the ACC through deeper integration, new payment reforms, and the promotion of whole-person/whole-family health.

In addition to our ACO payment structure experience we have helped our national clients with the following tasks, helping them to move from the design phase and through program implementation:

- Designing ACO operations and governance
- Determining ACO core capabilities
- Defining ACO services
- Identifying performance measures and measuring quality
- Assessing data collection capabilities and developing the appropriate system to gather data
- Developing data analytic tools and reporting capabilities

RFI

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

Our response contains more general comments around payment structure that we have garnered from our national experience with both state Medicaid programs and commercial ACO programs. Therefore, we have classified our response under question #64 of the RFI. This response includes the following:

- Considerations on program and payment design parameters
- Considerations in the level of risk to include in ACC payments
- Considerations on determining services to include in payment reform
- Considerations on RCCO payment distribution

Considerations on program and payment design parameters

While Colorado will be able to leverage the existing program and payment design when reforming the ACC program, the State should consider reassessing the core design parameters to verify that the structure is appropriate for any additional populations, services, provider types, etc.

Colorado should considered reviewing and reassessing the following aspects during the reform process:

- **Attribution** – An open group attribution methodology has been utilized by various states, such as Minnesota and Maine. An attribution process should be conducted during both the benchmark and performance periods to provide consistency in the population included for both periods. The existing

ACC attribution process may not be valid if new services or populations are added. Populations with specialized needs may require services not currently part of the attribution process that should be considered when attributing them.

- **Excluded Services** – Other states have considered services as excludable if that service isn't an alternate option for a covered service. In other words, if a covered service could shift costs to an excluded service

  to create artificial savings then that service should be included. We supported the State of Maine in assessing the services utilized by participating members. Maine then identified specific "core" services that were required to include in the program and "optional" services that participating ACOs could elect to include in their risk sharing arrangement.

- **Risk Sharing** – Other states have included a two-sided (i.e. shared savings as well as shared losses) risk sharing feature in their ACO programs to further provide incentives to the providers. The risk sharing considerations are further discussed in the following section.

- **Quality Metrics** – Based on the population being served quality metrics should be reassessed to make sure that they tie to the shared savings/losses payments and are appropriate for the covered populations to improve care quality.

- **Benchmark Setting** – Other states have implemented retrospective trend adjustments when setting the benchmark to avoid artificial savings/losses that are driven by inaccurate trends. This is consistent with the MSSP and Pioneer ACO programs, as well as a CMS recommended approach.

- **Catastrophic Claims** – Some states cap the benchmark and performance period member total cost of care at various thresholds to reduce variation from catastrophic claims. CMS typically requires an assessment of catastrophic claims and it's also important to protect ACOs from the risk of catastrophic claims.

- **Risk Adjustment** – Risk adjusting the ACC benchmark to be on the risk level of the performance to account for shifts in population health for more accurate shared savings/losses calculation is important as the ACC program expands.

- **Payment Model** – The payment model for ACO program varies across states and should be tailored for Colorado. As the ACC program is reformed, the payments for populations not currently included in the ACC program should be considered and potentially carried forward as a starting point to minimize service disruption.

- **Program Parameters** – ACO program parameters should reflect state-specific experience, goals, and population covered. We recommend performing analyses based on Colorado specific data to determine the appropriate program parameters for the covered population and services.

- **Covered Services** – The population included in the ACC program as well as the program goals and desired outcomes will help determine what services should be covered. Colorado should perform an

assessment of the population to be added and the services utilized by those individuals to help identify the appropriate services to be covered.

Considerations in the level of risk to include in ACC payments

To truly drive change, the ACC model should attribute some risk to the providers. Models in which providers do not have any downside risk have been found ineffective in driving change. While we have observed this in our own experience with providers and health plans, we point to the position purported in the May 2013 SOA Health Watch stating "*it was essential that the providers take downside risk as part of our ACO agreements, as incentive plans that use both 'carrots' and 'sticks' are more effective in engaging providers to work toward desired outcomes*" describing the successful implementation of ACOs by Blue Cross Blue Shield.

The next questions are the form in which risk transferred and the amount of risk. It is appropriate to limit the amount of risk transferred to providers.

- Limiting downside risk will likely be necessary to encourage participation early on (e.g. since this is new territory, anecdotal evidence such as Dean Health's adverse experience with Medicare Shared Savings Program may bias providers).

- Limiting overall risk may be fiscally appropriate as few providers have the expertise in assessing risk exposure and may serve to protect providers from adverse outcomes (a la statutory regulations with insurance companies and health plans) and the longevity of the program. As an ACO matures, providers should be encouraged to build out their expertise in risk analysis by partnering with health plans or engaging in those practices; with this, the State may allow providers to take on more risk.

- Some risk limitations will serve as protections for the providers while some may enhance an ACO's focus on improving utilization and quality of care.

In order to transfer an appropriate amount of risk to providers, a minimum and maximum level of risk should be implemented within the ACC program. We would recommend performing a statistical analysis to analyze the Minimum Savings Rate (MSR) and Maximum Savings/Loss Rate for the payment design structure based on Colorado Medicaid specific data. The statistical analysis will help the State understand the MSR needed for the population size and services included in the program design. The MSR risk measure ensures that the program is generating real savings due to delivery system improvement and better care coordination rather than random volatility of the data. The statistical analysis also places a boundary on catastrophic risk by putting an upper boundary on savings and loss payments for each ACC.

In addition to a MSR and Maximum Savings/Loss rate, the ACC can consider claim caps which will further encourage providers to participate by limiting their downside risk. This can vary with enrollment.

Considerations on determining services to include in payment reform

As the ACC program looks to further promote whole-person/whole-family health, the services incorporated into the payment methodology and risk sharing should be considered. There is not a specific list of services which we would recommend to be included or excluded from a risk-based reimbursement. The services to include depend on the population being served, the prevalence of the services for the covered population, the demographics of that population and the program goals.

Such considerations include (but are not limited to):

- **Overall program goals** – the included services should align with the goals that the State is trying to achieve and populations that the State is looking to include
- **Prevalence of service** – services that account for a majority of the expenses may want to be included in risk-based reimbursement due to largest opportunities presented
- **Overlapping services** – the State may want to consider excluding services that have already been managed via other Colorado Medicaid initiative programs
- **Potential for cost-shifting** – the State may want to consider the potential for cost-shifting especially if only some services are included in the risk-based reimbursement. For instance, providers may push more hospital care to long-term home and community based care if hospital care is included in riskbased reimbursement while the latter is not. The shifted cost should be taken into account when measuring the "actual" savings
- **Administrative expenses** – the State may want to consider if expenses which do not directly relate to the care delivered but improve the quality of care and operational efficiencies, such as care coordination, service monitoring, etc., should be reflected in the risk-based reimbursement
- **ACO willingness and capability to take on risks** – the State may want to consider if the services to be included in risk-based reimbursement would present unreasonable financial risk to the participating ACOs
- **Impact on quality and access** – ultimately, the list of services to be included or excluded from a riskbased reimbursement should not negatively affect the quality of care and patient access

Considerations on RCCO payment distribution

The RCCO should provide payments and any shared savings payment to (or recoup shared loss payments from) the ACC Lead Entity within each ACC. The ACC Lead Entity would be responsible for ensuring the provision of locating, coordinating and monitoring activities. Any subsequent payments to network providers will depend on agreements between the lead and other network providers.

If a FFS payment methodology is utilized, all ACC network providers would be paid FFS for the covered services that are incurred during the performance year. At the end of the performance year, total costs of care for the covered services incurred by assigned patients would be calculated and compared to the benchmark cost, and shared savings/losses can then be calculated and distributed amongst the RCCO and ACC Lead Entities.

If a capitation payment methodology is utilized, capitation payments would be made to ACC Lead Entities. Depending on the ACC program design, bonus payments or withholds from the capitation payment arrangements will also be made between the State and ACC Lead Entities.

We have observed some struggles from prospective payment arrangements (for example, bundled payments) in value based care implementation, which makes the FFS payment methodology more appealing. However, an

appropriate payment methodology should be chosen to best fit the goals of the ACC program and the current state of the Medicaid program.

Additional Background on Deloitte Consulting LLP (Deloitte)

Deloitte is the largest global consulting firm with over 100 offices across the nation, including a local Denver office in Colorado.

Leading Health Care Practice

As one of the leading health care consulting service providers in the country, Deloitte provides services through a broad network of practitioners to our state health, federal health, and commercial health care clients. Our professionals include, but not limited to, health actuaries, project managers, CPAs, data experts, risk adjustments rate experts, systems experts, data specialists, nurses, physicians, pharmacists, CMS policy authorities, health program professionals and claims specialists.

The following table highlights the breadth and depth of Deloitte's role and experience in the health care system:

Function Overview	Highlights
Consulting Practice	• More than 44,000 consulting practitioners serving over 150 countries/locations • Serves over 80% of Fortune 500 companies
Life Sciences and Health Care Practice	• A Life Sciences and Health Care practice that is among the largest in the world: 3,900 professionals in the United States • Life Sciences & Health Care experience of more than 70 years
Public Sector and State Government Consulting	• More than 10,000 practitioners supporting the Public Sector industry, having served 47 of 50 states, including the District of Columbia, Puerto Rico, and Guam • More than 3,000 practitioners supporting the state government sector with offices in 22 state capitals • More than 2,000 practitioners focused on health care and human services
Health Actuarial Consulting	• One of the largest health actuarial practices in the U.S. with over 120 health actuarial professionals • Knowledge with the State of Colorado programs
Clinical, Policy and Program Experts	• Physicians, clinicians, pharmacists, nurses and policy professionals • Deloitte resources who have served as CMS Policy Authorities

More specifically, for our value-based care clients, including ACOs, we provide services with our multidisciplinary team of health care professionals with a focus on executable strategy that is co-led by four senior professionals in the following disciplines: medicine, health plans, actuarial services and health information technology and analytics.

Deloitte has spent the last five years in focused work on accountable care enterprises across all stakeholders in the health care eco-system: health systems, physician practices, health plans, third party administrators, pharmacy benefit management companies, life sciences companies, state and local governments, employers, and federal health providers.

Vast Public Sector and Specific Medicaid Program Experience

Deloitte has a consistent nearly 50 year record of service on Medicaid and public health management issues. We have also worked with several states in planning major Medicaid waiver initiatives to facilitate program expansion and assessing program design to transform Medicaid delivery and reimbursement.

Our consultancy includes more than 1,000 public sector professionals dedicated exclusively to government programs, initiatives, and clients

- *44 of the 50 U.S. states*
- *15 of the 20 largest U.S. cities*
- *12 of the 20 largest U.S. counties*
- *30 agencies in the U.S. Federal government*
- *More than 30 higher education institutions in the U.S.*
- *More than 20 of the largest school districts in the U.S.*

Specifically with the State of Colorado Medicaid program, members of the Deloitte team have worked with Department of Health Care Policy and Financing on a number of initiatives related to physical health, behavioral health, PACE, and Children's PRTF. The services provided include:

- Certified capitation rates for each program
- Reviewed State's rate-setting methodology
- Provided support/defense for any future issues that may arise regarding calculations made by the contractor
- Calculated an all-inclusive per diem rate for Psychiatric Residential Treatment Facilities

Representative ACO Experience - MaineCare Accountable Communities Initiative

The State of Maine Department of Health and Human Services ("DHHS") received a SIM Testing grant and is pursuing implementation of an Accountable Communities program for their Medicaid population. The goals of the program are to strengthen access to primary care, increase transparency of cost and quality and reward providers for their performance.

Deloitte Consulting provided the State of Maine DHHS with actuarial analysis to assist DHHS in obtaining approval from CMS for their program. Deloitte performed the following key work steps to achieve these results:

- Performed reasonability checks on the data and verified reliability with aggregate State financial reports
- Warehoused three years of historical FFS Medicaid claims and enrollment data, added additional data fields and cleansed the data for duplicate or invalid data
- Performed sensitivity analysis on program parameters to assist DHHS in obtaining program approval from CMS
- Provided assistance on program design including member attribution and program parameters
- Provided insights into and performed member attribution for all Accountable Communities

- Calculated benchmark PMPMs for all Accountable Communities after normalizing, trending, risk adjusting, and performing other data adjustments
- Conducted various webinars to share program details, attribution methodology, and benchmark PMPM methodology with Accountable Care providers

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 063

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

Response to Colorado Department of Health Care Policy and Financing Request for Information

RFI UHAA 2015000017 Accountable Care Collaborative

November 24, 2014

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RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Colorado Community Health Alliance
Location: Denver, Denver County, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Click here to enter text.
Location: City, County, State.
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☒ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☒ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:

CCHA is currently the RCCO for Region 6 serving Boulder, Broomfield, Clear Creek, Gilpin and Jefferson counties

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Current RCCO for Region 6

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

There are several things that CCHA feels are currently working well in the ACC. For one, the Department has a non-prescriptive approach on how RCCOs utilize per member per month and Key Performance Indicator funds, which is allowing different models to emerge and be tested. Also, the ACC appropriately places an emphasis on primary care and has allocated some funding to help practices successfully move towards the medical home model. In addition, the ACC is encouraging providers across care settings and other community partners to begin collaborating in new ways that benefit the Medicaid clients and overall health care system.

2) What is not working well in the ACC Program?

The following are the primary areas we've identified with the ACC Program and Medicaid in general that cause confusion for providers and clients and could be improved upon.

Currently there are more than 20 quality/performance metrics that impact ACC providers. Our experience is that this is causing some providers to feel overwhelmed and unclear about the goals and direction of the ACC Program. Some efforts have been initiated to make metrics as similar as possible among all payers for Medicaid, Medicare and commercial contracts. Continued strides need to be made to move in this direction, rather than creating additional metrics that vary across programs/plans.

In addition, there are a number of primary care medical providers with patient rosters that include Medicaid ACC clients from multiple RCCOs as well as Medicaid clients not enrolled in the ACC program. This can cause additional confusion, as each option provides different levels of support services and reimbursement rates. We believe it would be beneficial to better align PCMPs with RCCOs and all Medicaid recipients in the ACC program.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

Having a dedicated entity, such as a BHO, that focuses on providing and expanding behavioral health care services to Medicaid clients is a good thing. Program oversight from the Department ensures the BHOs are performing at an acceptable level with regard to quality outcomes and standards for access to care. The mandated Performance Improvement Plan (PIP) helps promote continued innovation with care delivery for clients with behavioral health needs.

4) What is not working well in the BHO system?

Delivering behavioral health care services to Medicaid clients is complex and requires system flexibility. Unfortunately, there is little to no flexibility in the current BHO system. There needs to be more support for movement towards whole person health that recognizes the importance of integrating behavioral and physical health care, as not all disease states fit perfectly into defined buckets. There are diagnoses such as substance abuse that can fall between or cross over the responsibility of the mental health provider and PCMP. As a result, it can be very challenging to coordinate care and obtain authorization for treatment. And the current

payment structure can cause conflict as to which provider is responsible for care. To help alleviate this, the Department should finalize its efforts to integrate substance abuse with mental health funding.

5) What is working well with RCCO and BHO collaboration right now?

In Region 6, serving Boulder, Broomfield, Clear Creek, Gilpin and Jefferson counties, there is an exact overlap of the RCCO and BHO boundaries. This is highly beneficial and has allowed CCHA to focus collaborative efforts on a single BHO. Once a relationship was established with the BHO, Foothills Behavioral Health Partners, it became clear that we all had similar values and goals and sharing data was a logical next step. After all necessary business associate agreements were in place to allow for sharing of data in compliance with HIPAA rules and regulations, we were able to combine the physical and behavioral data for targeted care coordination of clients and initiatives to improve population health.

6) What is not working well with RCCO and BHO collaboration right now?

CCHA has established a relationship with Foothills Behavioral Health Partners that fosters collaboration for integrated behavioral and physical health care, and our partnership is working well at this time.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Separate funding streams have historically prevented meaningful integration of behavioral and physical health care. Specific to Medicaid, capitated behavioral health payments to the BHOs and fee-for-service payments for most hospitals as well as professional and ancillary services creates different incentives, lower outcomes than should be expected, and a higher total cost of care. One of the next steps toward a shift in focus to whole person care should include efforts toward a shift in payment models that provides more consistent incentive for delivering value based care. As the ACC continues to mature, the Department should look for RCCO candidates that are able to manage a blended behavioral and physical payment.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services. Using the table below, please explain which issues are barriers, and how they can be addressed:**

All of the factors listed below are barriers to a degree, but from our experience Privacy Laws (HIPAA, 42 CFR) and Different Behavioral/Physical Health Reimbursements are of the most concern.

Factor:	Barrier? Yes	Barrier? No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☒	
Community Behavioral Health Services Rule	☐	☒	
Covered diagnoses list	☐	☒	
Different behavioral / physical health reimbursement	☒	☐	Different reimbursements for behavioral and physical care create different incentives among different providers. We believe a positive next step would be to develop a payment model that drives value-based care and rewards providers across the health care system for delivering appropriate, cost-effective services.
Institutions for Mental Diseases exclusion	☐	☒	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☒	
PCMP financing structure	☒	☐	In the current fee-for-service payment environment it is nearly impossible for a PCMP to collect enough revenue to cover the costs of providing behavioral health services.
Per-member per-month amount	☒	☐	The current $4 PCMP PMPM is not sufficient to cover the costs of providing behavioral health services.
Physical space constraints	☒	☐	Some PCMPs have space constraints that would prevent them from providing behavioral health services at their practices.
Privacy Laws (HIPAA, 42 CFR)	☒	☐	While privacy laws are a necessity, they are also a barrier because they lead providers to be overly cautious and concerned about not being in compliance. As a result, there is valuable information that is not being shared between providers

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

			(such as PCMPs and behavioral health providers), which impacts quality of care. This issue can be addressed in part by legislative action to redraft prohibitive sections of the laws and also by continued dialogue in the community regarding appropriate and legal ways to share patient information.
Professional / cultural divisions	☐	☒	
RCCO or BHO contracts	☒	☐	A combined RCCO/BHO contract would further encourage behavioral health integration into new setting.
Staff capacity	☒	☐	Without adequate funding, it impossible for PCMPs to appropriately staff.
State/Federal rules or reporting requirements	☐	☒	
Technical resources / data sharing	☐	☒	The rules surrounding sharing of behavioral and substance abuse data are not well understood and limit appropriate and necessary data sharing. Simplification and clarification of the rules would be beneficial to providers and would ultimately result in increased data sharing.
Training	☐	☒	
Others			

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

There are different characteristics depending on whether the initial provider location is a primary care office or a community mental health center.

Assuming the provider location is a community mental health center, they would need to have a primary care provider on site, available, and interacting with the other team members to arrange for all the clients' basic primary care needs.

Regarding a primary care office, it is not a yes or no question but rather labeling different degrees of integration around the relationship to the behavioral health specialist. The most basic characteristic is the ability of a primary care office to make a referral to a behavioral health specialist and get meaningful information returned to them. The next higher or more advanced characteristic of integration is the presence of a co-located behavioral health specialist at the primary care office. In this scenario, the behavioral health specialist is typically employed by another agency and that agency does all billing for their services, which protects the primary care practice from financial losses. The final and most telling characteristic of a truly integrated primary care practice is the presence of a full-time behavioral health specialist that is employed by the primary care office and whose services are billed by the primary care practice.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

For a truly integrated model that includes behavioral health staff employed by and physically located at the PCMP practice, reimbursement to the PCMP must be considered first and foremost in any behavioral health integration discussion. If reimbursement is not set appropriately, there will be no incentive for providers to adopt change. All payers must equally support integration and align policies as much as possible to minimize confusion and different expectations by payer type.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

Care coordination should be patient-centered and focused on the whole person. This includes continuous collaboration with PCMPs, specialists, hospitals, urgent care centers, and behavioral health providers to more closely integrate care, improve bi-directional communication, and focus on the whole person to address their physical, behavioral and social health needs. By having a better picture of a client's overall health needs across care settings, we can provide more efficient, coordinated care – reducing hospital admissions/ER visits and avoiding unnecessary or redundant testing and procedures. This includes:

- Collaboration with providers within the medical neighborhood, as well as the State Data Analytics Contractor (SDAC) and Colorado Regional Health Information Organization (CORHIO), to implement processes and systems for sharing of client data across settings
- Analysis and utilization of shared data to more effectively manage the health of our clients, reduce unnecessary or inappropriate utilization, and ultimately lower total cost of care
- Identification of clients with chronic illness, or other high risk factors, through use of SDAC data and evidence-based criteria to initiate proactive client outreach, engagement, education, and care coordination
- Integration of physical and behavioral health through a diverse network of engaged providers, predictive modeling to hot-spot clients with significant medical and mental health needs and apply enhanced levels of care support, and co-location of services
- Continued care coordination and quality improvement services to help PCMP practices fully align with the patient-centered medical home model, operate more efficiently, achieve performance goals, and enhance client experience with care received
- Collaboration with county agency divisions that serve the ACC Medicaid population to determine how we can work together and best serve our clients' needs

b. How should RCCOs prioritize who receives care coordination first?

Care coordination should be based on client acuity, and then clients should be targeted into the right programs and level of intervention accordingly. Acuity can be evaluated based on factors such as:

- Complexity of physical health needs including single or multiple chronic conditions and/or co-morbidities
- Acuity and urgency of the care coordination needs
- Disease vs. social care coordination needs
- Activation of clients in making changes to their health care as based on the Patient Activation Measure (PAM)

c. How should RCCOs identify clients and families who need care coordination?

RCCOs should use various data sources to identify clients and families for care coordination support. These should include SDAC, internal analytics, utilization data and referrals from PCMPs, hospitals, specialists, community resources, government agencies, stakeholders, and client self-referral. RCCOs should also work

collaboratively with PCMP practices to identify clients that may need care coordination or additional services. Once identified, a complex health assessment should be conducted to determine the appropriate program/services.

d. **How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?**

To begin with, delegated medical providers should have sufficient systems in place to provide care coordination, including the ability to meet basic care coordination programs and functions provided by the RCCO for non-delegated providers. Examples include:

- Transitions of Care program
- Identification and outreach to high utilizers, specifically emergency department utilization
- Community care coordination (away from the provider's office)
- Proactive identification and outreach of high-risk clients
- Coordination and assistance with obtaining community and government resources
- Reporting of care coordination activities

The RCCO should monitor and track the delegated provider's care coordination activities via methods such as:

- Initial regularly scheduled meeting to discuss progress, barriers, etc., with new programs
- Monthly reporting from the delegated provider showing engagement efforts and success
- Quarterly analysis by the RCCO of delegate's Key Performance Indicators and other initiatives with feedback and corrective action as needed
- Annual on-site reviews

12) What services should be coordinated and are there services that should not be a part of care coordination?

Care coordination should be person-centered and services provided should be based on the needs as identified by the client and/or caregivers, their providers, and the appropriate care coordinators/ managers. In determining potential care coordination services, assessment should include but not be limited to clinical, functional, social, behavioral health, and financial status and needs.

These services should be identified using established care coordination techniques such as motivational interviewing and/or health coaching. Once services have been identified, the care coordinator should work with the client and provider to determine the appropriate person to assist with coordination. This would include identifying services the client and/or caregiver can coordinate, services other care coordinators in the community are providing, and services the RCCO should provide. The RCCO should be responsible for ensuring all services have been addressed during engagement with care coordination.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

To assess for care coordination needs, all information available from the client and/or data should be utilized to assist in identifying the care coordination needs. Data should be accurate and as close to "real time" as possible. Information should be obtained not only from electronic resources such as the SDAC or claims, but

also from the clients, caregivers, providers, and other care coordinators. Examples of information should include:

- Demographic data
- Clinical history
- Claims data
- Care plans from county/government agencies
- Real-time utilization data
- Community support system
- Psychological/social support

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

Care coordination takes place in multiple systems, with varying levels of intensity and different focuses. These systems include government and county agencies, hospital systems, community agencies, support systems, and providers and health care agencies.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

Care coordination provided outside the RCCO varies in services coordinated and differentiation in coordination. Some care coordination is focused on a specific clinical need or service, such as a transition of care program from a hospital, while others are more broadly focused on social or community needs. These care coordinators have various levels of expertise in the care coordination they provide. While some have broad understanding of the Medicaid system, most have a limited understanding. While the specific care coordination provided can be very successful in meeting specific care coordination goals, most care coordinators outside the RCCO or ACC do not have the whole-person approach delivered by the RCCO.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

An essential part of care coordination provided within the ACC Program should be to assess for other care coordinators and relationships with the clients. This assessment should occur at both the data level and through engagement with the client. The ACC should provide RCCOs with access to other county and government programs that are providing care coordination. Those clients should be identified in the data provided to include contact information for the care coordinators. In addition, care coordinators with the RCCOs should be working with the clients, caregivers, providers, etc., to identify care coordinators that have been working directly with the clients. Once additional care coordinators have been identified, the RCCO care coordinator should work with the client as the lead coordinator. The lead coordinator would be responsible for coordinating the services being provided by other coordinators and filling in the gaps to meet the clients' overall needs.

d. What are the gaps in care coordination across the continuum of care?

As stated in previous responses, care coordination happens at a multitude of levels, from a multitude of systems but varying organizations and people. Gaps in care coordination occur at an individual level based on the services, care coordinators and support systems to which each person has access.

While gaps are individualized at a member level, there are some barriers associated with providing care coordination. These barriers usually exist due to a lack of knowledge of available services, how to access services, and a state-wide understanding of the ACC, county services and community services that are available. In an attempt to understand these available care coordination services, we are compromised by differing HIPAA rules and access to real-time information. These barriers can then create unnecessary gaps in care coordination.

15) RCCOs' roles in addressing clients' and their families' non-medical needs. Please complete the table below, keeping in mind adults, children, and families:

During care coordination, the RCCO care coordinators should be assessing and working with the client to address all needs, including non-medical needs, that impact a client's overall health. All the needs listed below should be part of the comprehensive patient-centered care coordination assessment. The care coordinator should then work with the client to identify barriers, set goals and assist with providing referrals to resources to meet those goals. These referrals should include both community support and services and also knowledge of additional services available to the clients.

In working with community support and services provided by the Department and other government and county agencies, the RCCO should also have the ability to work directly with the agency to meet the needs of the highest risk clients. An example would be to work directly with Colorado Non-Emergency Medical Transportation (NEMT) to provide last-minute transportation to a provider's office if it will avoid an unnecessary emergency room visit.

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☒	
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	
Daycare / childcare	☒	☐	☒	

Economic stability & employment	☒	☐	☒	
Education	☒	☐	☒	
Environment	☒	☐	☒	
Food access / nutrition	☒	☐	☒	
Health literacy	☒	☐	☒	
Housing	☒	☐	☒	
Language or translation services	☒	☐	☒	
Literacy	☒	☐	☒	
Transportation	☒	☐	☒	
Other	.			

16) Requirements about who should be doing care coordination. Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

While everyone across the care continuum who is involved in a client's health care has a role in care coordination, CCHA feels there are two primary roles:

Providers – including PCMPs, specialists, etc.: Their role is to provide direct clinical services to clients to meet their physical and behavioral needs. While providing clinical services, they should be identifying potential care coordination needs and referring to care coordinators for support.

Care Coordinators – including patient navigators, health coaches, etc.: Their role is to provide care coordination for the clients as appropriate based on the position they hold. As care coordinators, they should be collaborating with the clients, providers, other care coordinators, and others involved with their health to identify goals and interventions, and also be communicating across the care spectrum.

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☒	Their role with care coordination will vary depending on whether they are employed in the capacity of a clinical provider or a care coordinator as defined above.
Certified Addiction Councilors	☐	☒	
Certified Nurse Midwives	☐	☒	
Community Health Workers	☒	☐	
Generalists (BA/BS/MA/MS)	☐	☒	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☒	☒	Their role with care coordination will vary depending on whether they are employed in the capacity of a clinical provider or a care coordinator as defined above.
Licensed Marriage and Family Therapist	☐	☒	
Licensed Mental Health Counselors	☐	☒	
Licensed Professional Counselor	☐	☒	
Masters of Public Health	☐	☒	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☒	An exception would be the Medical Director of the RCCO
Nurse Practitioners	☐	☒	
Patient Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☒	☐	
Psychiatrists	☐	☒	
Psychologists	☐	☒	
Registered Nurses	☒	☒	Their role with care coordination will vary depending on whether they are employed in the capacity of a clinical provider or a care coordinator as defined above.
Social Workers	☒	☐	
Wraparound facilitators	☐	☐	We do not have an opinion as to whether they should play a role in care coordination
Other			

17) Care coordination requirements for specific populations. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Care coordination programs should provide both general and specific care management interventions to all populations as needed. Based on the results of complex assessment of both clinical and non-clinical needs, clients may fall into either a specific or general care management program.

General care management programs: While these programs are not based on a specific evidence-based program, they are specific to the client and involve comprehensive assessment and person-centered goals and interventions. Level of engagement is based on client need and complexity of clinical and non-clinical needs.

Specific care management programs: Various evidence-based, specific care management programs can be used that target populations using data, best practices and nationally accepted guidelines.

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☒	
Children	☒	☒	
Children who are healthy, but in socially-complex environments	☒	☒	
Children involved in the foster care system	☒	☒	
Children with a chronic illness	☒	☒	
Children with a serious emotional disturbance	☒	☒	
Children with medical complexity	☒	☒	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☒	
Transition-age adolescents	☒	☒	
Parents and families	☒	☒	
Pregnant women	☒	☒	
Adults	☒	☒	
Adults who are healthy, but in socially-complex situations	☒	☒	
Adults with a chronic illness	☒	☒	
Adults with a behavioral health diagnosis or substance use disorder	☒	☒	
Clients involved in the criminal justice system	☒	☒	
Clients with a disability	☒	☒	
Clients in a nursing facility	☒	☒	
Elderly clients	☒	☒	
Frail elderly clients	☒	☒	
Clients in palliative care	☒	☒	

Other populations, please comment:

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

RCCOs should work with both foster care systems and other child-serving agencies such as Healthy Communities to proactively identify shared clients. Once clients are identified, care coordinators with the RCCOs and agencies should collaborate to identify client-needed services and coordinate to fill any gaps. There should also be cross-education about each other's programs, and Business Associate Agreements should be obtained to allow for ease of coordination and communication.

19) How should care coordination be evaluated? How should its outcomes be measured?

In addition to utilizing claims based or clinical data, care coordination evaluation needs to incorporate client feedback in assessing the quality and effectiveness of the care coordination. This should encompass whether we actually met the patient's health goals, as well as any non-medical needs such as housing or special services. Care plan creation and coordination across the health care system is very important in helping clients meet their health outcome goals. Examples of patient-reported measures we could evaluate include experience of care, functional status, and outcomes.

In addition, measures that are designed to reflect the varying strengths and needs within each community would strengthen the medical neighborhood concept. Quality and safety measures such as readmission, medication reconciliation, and care coordination that drive costs in the system should also be evaluated.

We would recommend narrowing the patient population to measures that are tied to incentives payments, such as coordination measures that are tied to managing chronic conditions.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

Over the past three years, the RCCO PMPM payment has decreased by approximately 35% while the required scope of work has expanded. Nearly the entire $8-$9 PMPM is required to provide the necessary care coordination services for the enrolled ACC Medicaid members.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

No, it is generally not advisable to have the PMPM vary by specific populations, as these assumptions frequently underestimate or overestimate the level of need for a given population. An exception may be varying the PMPM for extreme known differences in level of care required for populations such as children and persons with disabilities and/or chronic disease. If the level of care is known to consistently be significant, varying PMPM could be valuable. For populations that fall in the middle, there is more room for variations in level of care within these groups. Conducting the ongoing necessary analysis for all populations adds

unnecessary administrative cost. Ease of administration should be considered so RCCOs can focus their efforts on activities that impact the ACC clients.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

CCHA does not recommend setting specific care coordinator to client ratio requirements for several reasons. First, simply setting ratios will not necessarily provide meaningful measurement of program results and/or activity of care coordination programs. To achieve positive results in patient outcomes, cost and/or client satisfaction, we believe it is important to first assess whether the "right" clients are selected to receive care coordination services. A successful care coordination model begins by targeting appropriate clients for care management. Although it is always desirable to be able to serve all clients with services, any program will have limited resources to fund these services. By working closely with the provider community and patient groups, using data to target those clients most appropriate for care coordination services is necessary.

A second factor that influences care coordination ratios is the type of care coordination model that is most appropriate for the client's needs and acuity. For the highest acuity, it is often necessary to have numerous face-to-face visits in the client's home environment or health care settings such as provider offices or hospitals. In some segments of the ACC client population, telephonic outreach and monitoring can be effective.

The client work load varies vastly in each of these models. CCHA is committed to working with the Department to provide meaningful information on how we target, outreach and measure activity and results for all programs. Through our long history of providing care coordination services, it is our experience that blanket ratios do not accurately tell the story for the reasons listed above.

a. **Care coordinator to client ratios. If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:**

As stated in response to the previous question, CCHA does not recommend that care coordinator to client ratios be part of the next RFP.

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

The Department should focus on metrics that aim to improve care coordination across the overall health care system and achieve an improvement in the health status of individuals, families and communities. CCHA recommends utilizing both process and outcome measures to assess the effectiveness of care coordination across the system.

We understand that there are very few care coordination metrics that are developed to measures across the system but recommend that the Department utilize nationally endorsed care coordination measures as much as possible from organizations like National Quality Forum (NQF), National Committee for Quality Assurance (NCQA), or Agency for Healthcare Research and Quality (AHRQ).

Sample RCCO Level Process Measures:

- Number and level of participation of organizations involved in the care coordination
- Number of clients receiving services from a care coordinator
- Number of clients enrolled in a care management program

Sample Provider Process Measures:

- Number of duplicated/unduplicated encounters
- Number of clients referred
- Number of referrals to care coordinators
- Number of case managed clients who have had X number of visits with their provider during a particular time period
- Number of participants who have a self-management plan

Sample Patient Outcome Measures:

- Changes in biometric measures including weight, waist circumference, body mass index, blood glucose levels, etc.
- Changes in ability to self-manage, including activities of daily living
- Changes in healthy behaviors
- Changes in knowledge
- Changes in transportation costs (e.g., streamlining visits with specialty providers)
- Perceptions
- Health outcomes

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

CCHA recommends that as the ACC continues, the RCCOs are able to continue to innovate and not only create new care coordination programs to address client-specific clinical and non-clinical needs, but also work with their community partners to pilot ideas. Two such ideas that we are currently piloting include working with the Jefferson County Hotspotting Alliance to address high emergency department utilization and with Clear Creek County to address transportation disparities in this rural area.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Requiring RCCOs to implement certain functions in the same way goes against one of the main principles of the ACC, which is to test different RCCO models. We believe a more beneficial structure would be to align PCMPs with only one RCCO, as this would help minimize confusion for all parties involved in care delivery for ACC clients – including the clients themselves and the Department.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Familiarity with the local providers and community is essential for RCCO success. A bidder for a RCCO region should be able to produce numerous letters of support from different community entities and providers in the region, articulating their familiarity and support for the bidder based on past experience with the bidder.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

In the Medicare Shared Savings Program, primary care physicians are only permitted to participate in one Accountable Care Organization (ACO) per contract period and all of their attributed clients are aligned to that ACO. Our recommendation would be that the ACC follow this model and better align RCCOs (hopefully which will become ACOs in the coming years) and PCMPs.

Initially, PCMPs and all of their attributed ACC clients would be enrolled with one RCCO, based on location of the practice and client address. Because different RCCOs offer different support services, we encourage alignment with a single RCCO to help alleviate confusion that occurs with the current model where a PCMP may be aligned with multiple RCCOs. From there, mechanisms could be put in place that would allow for PCMPs to choose which RCCO they want to align with, within boundaries that make sense (e.g., counties with neighboring borders).

Concepts can be borrowed from the Medicare Advantage plans where plans are incented to receive "5 star" quality rankings to allow Medicare beneficiaries to select them throughout the year instead of the limited two months of open enrollment. The Department could assign "stars" to the RCCOs based on similar quality and performance metrics that would allow a PCMP from outside the RCCO's county boundaries to select them as their aligned RCCO. We realize that operationalizing this proposal may be challenging but recommend that the Department consider a shift in this direction.

27) Should the RCCO region maps change? Why or why not? If so, how?

In areas of the state where the RCCO and BHO boundaries are not the same, one of them has to conform to the other. Among other things, it creates unnecessary artificial boundaries and additional administrative hurdles when the boundaries are not aligned.

28) Should the BHO region maps change? Why or why not? If so, how?

See our response to question 27 above.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

Transitioning a RCCO's current scope of work to a new vendor would require at least six months to become operational and approximately nine months to become relatively effective. The learning curve and timeline would be longer for an organization that has not previously been a RCCO. There are efficiencies with transition between existing RCCOs.

At a high level the transition of work can be categorized into three buckets of activity to include care coordination, PCMP transition, and establishing relationships with community resources. For care coordination, all client cases would need to be transitioned and the new vendor would need to establish contacts and embed care coordinators in PCMP practices. For PCMP transition, the re-contracting process would probably be most time consuming. For community resources, it would take time for the new vendor and community agencies to build new relationships and collaborative partnerships. All three buckets would involve efforts such as fostering new relationships, remarketing and educating regarding services available through the new RCCO, establishing and implementing processes, and orientation to new systems.

The expenses involved with a transition would be significant and include operationalizing the above three buckets of work. The transition timeline and relative expense would be dependent on the size and number of enrolled ACC clients.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

The rising total cost of Medicaid expenditures is an issue for Colorado and the nation. One of the contributing factors is over utilization of hospital emergency rooms and the downstream consequences. We believe that one way to help reduce non-emergent visits to the ER is to implement a client co-payment of $20. The intent of the ER copay is to add a layer of financial responsibility for the clients that will lead them to reconsider going to the ER instead of their PCMP for non-emergent care. Over time this would have the added benefit of increasing primary care utilization assuming appropriate capacity. Implementation of a co-pay would need to run parallel with increased PCMP accessibility and expansion of PCMP participation in the ACC. Such an effort to implement an ER co-pay for Medicaid clients would be unprecedented and require cooperation from almost all stakeholders including hospitals as well as state and local government agencies.

Also, there are currently not enough specialists accepting Medicaid referrals in Colorado. Many Medicaid clients are not able to access specialist care and often end up in the emergency room or receive surgery or other procedures that could have been avoided. Specialist participation in the Medicaid program is limited by many factors but low financial reimbursement seems to be the most significant. Assuming the Department cannot reimburse specialists the equivalent of Medicare reimbursement, legislative action is required to increase specialist participation because accepting Medicaid is currently a competitive disadvantage in a competitive health care market. Increased participation could be achieved by mandating that any specialist in Colorado must have at least 5% of their total visits comprise of Medicaid clients in order to maintain a Colorado medical license. With this mandate, no single entity would be disadvantaged by seeing Medicaid

clients. And we believe that top medical talent will continue to flood to Colorado regardless of such a mandate.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

The current Medicaid benefit structure is adequate. However, we recommend that the month-to-month eligibility determination for adult Medicaid clients be changed to an annual benefit. Expanding to a one-year coverage period would provide additional stability for the Medicaid client, reduce administrative efforts placed on continually re-determining eligibility, and allow the RCCO and primary care medical provider more time to establish a relationship with the client before potentially dropping out of Medicaid.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

No. In our experience, there should only be one RCCO per region. The potential benefits from RCCO competition within a region do not outweigh the guaranteed added confusion to the many social resources, clients, PCMPs, and other providers.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

Not applicable for a RCCO respondent.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

RCCOs should have the ability to attribute enrolled ACC clients to contracted PCMPs. If the RCCOs are engaged in a shared risk or shared savings program with the Department for this population, it is in their best financial effort to make a meaningful PCMP attribution to increase primary care utilization and decrease less appropriate utilization.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

The Colorado Department of Public Health and Environment (CDPHE) often engages in numerous projects and pilots that are directly related to the care of clients in the ACC Program. However, as an organization it feels as though they have not been engaged in ACC operations. There needs to be better alignment of program implementation and the goals of the ACC. For example, the Vaccines for Children program, though well intended, has created access issues for many Medicaid clients. The RCCOs could very much benefit from CDPHE collaboration in this matter.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

The RCCOs often connect clients with services administered by the Colorado Department of Human Services (CDHS). It would be nice to have a tie with CDHS to ensure up-to-date information on any program changes or

new programs available to ACC clients. It would also be a worthwhile exercise to learn more about how CDHS views their outcomes and if the ACC can align with their efforts.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace/ Connect for Health Colorado?

The link between the ACC Program and Connect for Health Colorado is only applicable for those clients able to transition out of Medicaid. Medicaid clients with disabilities and clients who are currently not above the Federal Poverty Level will likely remain covered under the Medicaid program. The clients who transition out of Medicaid and into a commercial plan would be prime clients for a state and RCCO sponsored plan. Assuming this is true, the Department should consider creating a Qualified Health Plan as an option for this population.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

The types of collaboration between the ACC Program, Division of Insurance, and Department of Regulatory Agencies depend on the RCCO scope of work and compensation methodology. If a RCCO assumed substantial financial risk, it would need to collaborate with the DOI and DORA. Assuming no substantial financial risk, collaboration may not be necessary.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

Clinical delivery of our programs and especially cultural competency should include feedback from clients, clients' families, and client advocates. The inclusion of a format that provides and solicits feedback from the stated categories on clinical delivery is supported by CCHA. As it pertains to RCCO operations, CCHA would recommend that stakeholder engagement be limited.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

Engagement with providers, community organizations and social services is key to program performance. CCHA would hesitate to mandate such engagement, as we are limited by the other entities' interest in participation. Outreach and availability should be the requirement, not actual engagement.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

Given the tremendous variety of local community groups providing client services, being informed of these entities is the first key step. The RCCOs can benefit from continued support from the Department on identifying and connecting with community entities.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

The current structure provides good insight, but it appears that only a portion of stakeholders statewide actually participate. While input from participating stakeholders is appreciated and helpful, currently they do not represent the state as a whole. A mechanism that solicits engagement statewide and maintains statewide perspective would be advised.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

CCHA has not had an issue to date with finding a PCMP for clients that inquire. We are also not aware of any issues with clients finding and accessing hospitals, pharmacies, or home health services.

a. **If no, what are the gaps?**

There is a shortage of specialists in Region 6 who accept Medicaid referrals, primarily in the specialty areas of orthopedics, neurology, urology, and pain management. With regard to dental, CCHA is assisting DentaQuest with a dental recruitment project in Region 6. Our assumption is that there is a shortage of dentists due to the lack of historical adult benefits, but the extent of the gap is not yet known.

b. **Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.**

The Vaccines for Children (VFC) program continues to be a barrier in providing vaccinations for children. CCHA has been unable to obtain a VFC provider list to help direct clients, and we have had numerous complaints from pediatricians concerning the VFC program.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. **What role should hospitals play in the next iteration of the ACC Program?**

The need for real-time hospital utilization data continues to be a need. In addition, hospitals should be more engaged in the stakeholder process. Most hospitals in the state are engaged in the ACC program to some degree, but hospitals should be more engaged in the stakeholder process. In the next iteration of the ACC, hospitals should be measured on ACC engagement and their Medicaid reimbursement should be tied to it much like the current Medicare hospital payment initiatives. Potential metrics could gauge data sharing or care coordination collaboration. RCCOs also need to be aware of hospital perspective and financial motivations.

b. **What role should pharmacies play in the next iteration of the ACC Program?**

Pharmacy participation has yet to be explored. However, partnerships centered on high opioid users should be a consideration.

c. **What role should specialists play in the next iteration of the ACC Program?**

At this point, specialists have been minimally engaged in the ACC program. A means to incentivize participation must be discussed.

d. What role should home health play in the next iteration of the ACC Program?

We would recommend considering the possibility of a limited network of home health agencies that are vetted by each RCCO.

e. What role should hospice care play in the next iteration of the ACC Program?

Per the Medicare-Medicaid Program protocols, RCCOs need to build relationships with local hospice providers. We would recommend waiting for results of these efforts before speculating on potential collaborations.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

The relationship between SEPs, CCBs and RCCOs is necessary to avoid duplicative services. All RCCOs have made some attempt to collaborate with the SEPS and CCBs. In any cases where this attempt hasn't worked, the resistance has come from SEPs and/or CCBs. We would recommend considering alteration to SEP and CCB contracts to mandate participation in the ACC.

g. What role should counties play in the next iteration of the ACC Program?

County agencies provide vital client services to many ACC clients. The RCCOs need to be familiar with programs and services available in order to route clients effectively.

h. What role should local public health agencies play in the next iteration of the ACC Program?

The ACC should align programmatic efforts with public health campaigns as much as possible to leverage our joint efforts.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

We don't currently have enough information on these entities to formulate an opinion.

45) How can RCCOs help to support clients and families in making and keeping appointments?

RCCOs should assist their clients with making and keeping both clinical and non-clinical appointments, with the level of assistance being based on the clients' needs. The goal is to ensure that clients and their families have access to the needed resources and understand the importance of keeping those appointments.

For higher functioning clients, RCCOs can provide information on needed providers and transportation resources, and clients can schedule and attend appointments. For lower-functioning clients, RCCOs can provide a higher level of assistance to include actively making the appointments, arranging transportation, providing reminders, and if needed, attending appointments with the clients. We have found that the biggest barrier with making and keeping appointments is transportation and feel this is an area of opportunity to pilot innovative solutions for alternate transportation options based on assessment of clients' needs.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

CCHA believes that to provide successful care coordination, it should be tailored to the client's acuity and needs. Requiring a specific type of care coordinator or health coach may not result in improving care coordination or client outcomes. CCHA supports collaboration with already existing care coordinators, including community health workers and would continue to collaborate to meet the client's needs. However, we do not recommend creating mandatory requirements for utilizing community health workers and patient navigators. The current format has yet to incorporate principles that align with non-grant funded entities. While community health workers and patient navigators provide necessary client services that should be supported, the outcomes of this work are most beneficial to reducing uncompensated hospital care. Inclusion into the RCCO contracts would create an unnecessary burden. We believe there are potential solutions outside of the RCCO contracts.

47) Community Health Worker reimbursement. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

We do not believe any of the presented options are sustainable for the following reasons:

Independent Bill: Billing community health worker services to Medicaid would require Medicaid to produce coding and budgeting to operationalize an independent billing scenario. This would create substantial administrative burden to Medicaid. However, if Medicaid is willing to undertake the efforts to support independent billing, we support this reimbursement method.

On staff (salary) PCMP Clinic: While some providers may have the ability to staff community health workers, many lack the infrastructure to support this type of employment. The decision to staff a community health worker would need to be done provider by provider. In addition, the work performed by community health workers staffed by PCMP practices would be duplicative of the work done by RCCO care coordinators co-located at practices.

On staff (salary) at RCCO: This option does offer some potential, given certain criteria. However, each RCCO must be free to make that decision based on parameters that take into account regional need, finances, population analytics, and business structure.

PMPM Payment: A PMPM payment structure is simply a type of payment methodology like contingent payments or fee schedule payments. Sustainability of this option would be dependent on whether Medicaid, PCMPs, or RCCOs would be paying the PMPM amount. Our responses above would apply accordingly.

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

A client's oral health has down-stream effects on physical health and in some cases drives avoidable emergency room utilization. RCCOs should play a role in coordinating client oral health needs and work in collaboration with DentaQuest to identify network gaps and support dental provider recruitment efforts.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

Cultural competence is the ability to provide care to clients with diverse values, beliefs and behaviors and the ability to tailor program delivery to meet clients' social, cultural and linguistic needs.

b. What RCCO requirements would ensure cultural competency?

Cultural competency training based on National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) should be mandatory for RCCO employees as well as employees of delegated entities. This training may not fully ensure cultural competency but will provide a core, consistent understanding and skills to more effectively ensure patients are getting access to health information and care based on their needs.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

There is no one strategy to combat low health literacy. Clients must be given a variety of opportunities to ask questions in a non-threatening environment. Providers and staff should be focused on delivering person-centered health information and services. This requires them to be sensitive to patients' cultural beliefs and practices and convey respect through the way they communicate and deliver care. In some cases providers and staff may need to get assistance from other staff members or external resources that are familiar with the patient's language, lifestyle, and beliefs or values. Providers and staff should be trained to ask appropriate questions to help them understand the circumstances of the particular patient and/or family rather than apply any preconceived ideas or cultural stereotypes they may have. CLAS training would be beneficial for developing core knowledge and skills that are useful in cross-cultural interactions. This training should be mandatory for delegated entities.

d. **Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?**

The RCCOs may be able to function as a health literacy resource either through client materials as feasible or possible client service call centers. While Medicaid currently staffs a client call center, the call volume arguably precludes their ability to function as a repository of health information. If the RCCOs could function in a capacity to support some of the general client service needs, we could help Medicaid caste a broader net. This function may also result in increased care coordination.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

A preferred network inherently means a limited provider network, which is traditionally good when managing insurance risk but does not facilitate patient access and choice. The current Medicaid managed care plans in Colorado have preferred networks. If the next ACC RFP allows a RCCO to take significant financial risk on a defined population, then the RCCO should be permitted to create and utilize a preferred network for specialty, facility, and ancillary care.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

As described in more detail in our response to question 30, the ACC should support implementation of a $20 client co-pay for emergency room services to help address the rising utilization for non-emergent needs. This would allow clients to receive the care they need for emergencies but encourage utilization of their PCMP rather than the ER for non-emergent medical concerns.

There also needs to be more consistent messaging and education around appropriate use of the ER and access to urgent appointments with primary care medical providers or after hours options other than the ER. Currently there is conflicting messaging regarding where to go for care. In order to implement initiatives to change the trend of high ER utilization, there will need to be collaboration and participation from various stakeholders within the health care community as well as state and local government agencies.

Also, as mentioned previously in our response to question 30, there needs to be strategy for increasing the number of specialists that accept Medicaid referrals. With the lack of specialist participation, Medicaid clients often unnecessarily end up in the emergency room instead.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

We can't begin to address the actual shortages in services until there is a clearly defined and calculable statewide understanding of network adequacy.

Practice Support

S3) Support for practices. Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☒
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☒	☐	☐	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☒	☐	☐	☐
Provide registries	☒	☐	☐	☒
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☒	☐	☐	☐
Supply behavioral health surveys	☒	☐	☐	☐
Supply other self-screening tools	☒	☐	☐	☐
Administer behavioral health surveys	☒	☐	☐	☐
Administer other self-screening tools	☒	☐	☐	☐
Prepare client action plans	☒	☐	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☒	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☒	☐	☐	☐
Provide standing pharmacy order templates	☒	☐	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☒
Provide directory of other resources	☒	☐	☐	☒
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

We do not recommend that specific tools be required for the practice and provider support categories listed above. Our experience working with a variety of systems, tools and software programs is that there are benefits as well as some trade-offs with all.

CCHA believes that the role of the RCCO/practice transformation team is to help ensure primary care provider practices have access to a variety of options. This allows them to decide which tools are the best fit for their unique needs, while effectively supporting their efforts to meet the goals of the Triple Aim. Many practices, RCCOs and other organizations have already invested a lot of financial and physical resources into implementing systems such as electronic health records and care management software to support coordinated care across health care providers. Requiring specific systems or tools such as these at this stage in the program would not be a feasible solution. However, the Department should consider identifying certain functionalities or outputs that are expected as an outcome of practice support. For example, rather than requiring a specific care management system, require that the system being utilized has certain functionality and ability to capture and produce necessary data. We also recommend leveraging CORHIO and any other health information exchange systems.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

The goal of PCMPs is to see patients and help them manage their health. Through the Affordable Care Act (ACA) and the Accountable Care Collaborative (ACC), new requirements, deliverables, programs, and initiatives are continuously being implemented. PCMPs are being required to not only understand their role as part of the ACA/ACC Program, but are also needing to implement electronic health records, build medical neighborhoods, and understand the different requirements of payers and programs.

We believe that RCCOs should assume the role of project managers for the ACC program to help PCMP practices understand the ACC Program and expectations of practices and how they align to other initiatives.

To support practices in achieving these goals, RCCOs should be required to provide the following:

Practice Coaching Support:

- Streamline ACC initiatives and help practices prioritize based on what is needed for the ACC Program as a whole but also balance with available practice resources
- Guide practices with implementing population management strategies
- Help ensure that great ideas are actually implemented instead of dying down because of lack of time or follow through, and that once processes or strategies are implemented they are sustainable over time
- Connect practices to other practices that have implemented similar strategies or processes so they can learn from each other and avoid recreating the wheel

Learning Collaborative/Roundtable Events:

- Organize periodic events for primary care practice providers and staff, as well as other partners and stakeholders within the community, with the goal of:
    - Sharing best practices and lessons learned
    - Discussing and brainstorming solutions for things that aren't working
    - Sharing tools and resources available for practices

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

We recommend that recognition for meeting qualifications of a medical home should align as much as possible with definitions that are already in place nationally. If a PCMP has gone through a national recognition process, the Department should allow them to use that national recognition towards the ACC Program.

The RCCOs and/or the Department should create a medical home score card that aligns with the goals of the Triple Aim and incorporates measures that other health plans or other national programs are using. Ideally the score card would include measures of success with highest ratings for things the PCMPs have control over and can realistically achieve. If RCCOs are going to make a positive impact on the system, incentives also need to be in place for other non-PCMP practices (e.g., emergency departments need to have an incentive or disincentive to help assure the health care system reduces preventable ER visit costs).

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

No, the Department should not require that PCMPs utilize disease registries. However, the Department should make a registry available and offer it to PCMPs. One option may be providing a system where providers can access a registry through their electronic health records (EHR) system. The Department is already incentivizing PCMP adoption of an EHR system through Meaningful Use. We would support the Department joining forces with Regional Extension Centers and the Colorado Regional Health Information Organization to require that EHR vendors provide a registry through their EHR system.

58) Please share any other advice or suggestions about provider support in the ACC.

There should be means by which the RCCOs can assist providers with issues around claims denial and financial reconciliation. RCCOs should be able to contact the state fiscal agent on behalf of providers in their networks.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

One of the primary goals of the ACC is to move PCMP practices toward the medical home model of care delivery that is patient centered, comprehensive, coordinated, and accessible with a commitment to quality and safety. The current payment structure to PCMPs supports this goal but does not do enough to promote significant change. The majority of a PCMP's reimbursement before and after the implementation of the ACC is still based on the number of times a PCMP bills a very similar set of CPT codes. A shift of paying for value of care over volume is required. One consideration may be a shared risk arrangement with PCMPs, along with promoting more efficient ways to deliver care. This could include services such as nurse triage via phone that may not generate billing activity but would reduce total costs of care and result in shared savings for PCMPs.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

Not applicable for a RCCO respondent.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Some providers may be willing to transition to a value-based payment model, but further understanding of financials would be necessary. These providers have considerable infrastructure in place that would support care that is driven by analytics and intensive client support to drive outcomes. However, there are also many providers that currently do not have the infrastructure necessary to be successful in a value-based model, and less-advanced practices depend on the current volume-based structure to maintain financial solvency. For these reasons, there needs to be a staged rather than global approach to a transition in payment structures, taking certain practice variables into consideration. RCCOs may be in a position to help support practice transformation that will prepare practices for successful transition to a value-based system.

A primary barrier to transition is that current payment methodologies are still geared toward volume-based care delivery rather than value-based, and at this time the financial models being presented by payers in the community are not providing enough financial support to sustain the desired changes.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

CCHA is not currently licensed by the DOI. A requirement to obtain either an LSLPN or HMO license would not necessarily preclude CCHA from bidding. However, the cost of obtaining such licensure and the purpose of obtaining such licensure would need to be further explored.

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

RCCOs should definitely play a role in the distribution of payments to providers, as we believe this would promote increased PCMP attention and responsiveness to the RCCOs. This should start with the Key Performance Indicator reimbursements flowing through the RCCOs to the PCMPs. As the RCCO's financial risk increases, additional funds should flow through the RCCO to the providers.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

Payment reform in any system is challenging if the intent is to shift where resources are spent or allocated. Payment reform in health care is especially difficult due to the complexity of health care. Therefore, everyone should have a realistic expectation of the time required for meaningful change in the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

Our recommendation is that the highest weighting is placed on measures that PCMPs have more control over, such as diabetes process and outcome measures, redirecting care from high cost facilities, and measuring patient satisfaction with their care. For consistency, it will also be helpful to align with performance measures adopted and utilized by other health plans, including Consumer Assessment of Healthcare Providers and Systems (CAHPS), National Quality Forum (NQF), and Healthcare Effectiveness Data and Information Set (HEDIS) measures. As mentioned in our response to question S6, incentives also need to be implemented for non-primary care providers such as emergency room departments.

66) Measuring Client experience. Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	We support using the CAHPS survey. However, there is a high cost to administer this survey at a RCCO level. We would need more details about who would be administering the survey.
SF-12 Health Survey	☒	☐	
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☒	☐	
Focus groups	☒	☐	
Other	Receiving the data for quality improvement purposes at a RCCO and/or PCMP level is very important to us.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

While claims data provides valuable information, there are also known gaps in data that result in inaccurate measures of performance. For example, if a client is newly enrolled in Medicaid and saw their PCMP for a well-child visit while enrolled in a non-Medicaid plan, it isn't captured in Medicaid claims data for several months and appears as a gap in care. We recommend that the Department allow PCMPs and RCCOs to supplement claims data with their own data sets to help fill these gaps.

In determining which metrics to include for measuring population health, they should be aligned with nationally accepted performance measures such as NQF and HEDIS that are adopted and utilized by other health plans. The more aligned we all are, the more successful we will be with making strides to improve population health.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

It is important that data be shared regularly with RCCOs and PCMPs so they continuously know where they stand and aren't caught off guard in terms of performance. Frequent reporting allows RCCOs and PCMPs to identify issues or concerns early on and implement quality improvement strategies accordingly. New measures should initially only be visible to RCCOs and PCMPs. RCCOs and PCMPs need to be given a sufficient amount of time for validation and improvement efforts before the data is made available to the public or used as a performance indicator. RCCOs and PCMPs should also be allowed to supplement information from their own data sources. If only claims data is being used, data may be inaccurate or important data may be missing.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7*	☒
8-10*	☒
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

*RCCOs and PCMPs do different work. Therefore, they cannot be measured in the exact same manner. The 5-7 range of measures seems appropriate for a PCMP. If there are too many measures, it is impossible for PCMPs to focus on all of them. With a smaller number of key measures to focus on, PCMPs are more likely to be successful with making improvements. RCCOs have a greater infrastructure and a larger scope of work compared to PCMPs, so 8-10 measures seems appropriate.

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%*	☒
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

*The current $1 RCCO withhold for Key Performance Indicator payments represents approximately 12% of the RCCO's total compensation. Under the current RCCO funding model, 12% is about right. However, if RCCOs move to an alternate payment model such as shared risk on the total cost of care, the percent tied to measures and performance would change. In this case, there would be several measures and performance metrics so it would not be relevant to compare to the current 12%.

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Yes, all RCCOs across each region should be paid on the same KPIs. This would not only help create a system of fairness but would increase the potential to make a collective impact within our state.

No, RCCOs and PCMPs should not be paid on the same KPIs but there should be some degree of overlap. RCCOs and PCMPs do different work and therefore cannot be measured and reimbursed in the exact same manner.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

When evaluating a RCCO's performance, both improvement and national standards should be considered. Because the ACC is in its relative infancy stage, weighting improvement heavier is logical. When Colorado and other states have more mature programs, it may make sense to add more weight to reimbursement based on national benchmarks.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

Yes, it is our recommendation that payment only be tied to measures where data is made available on a regular, frequent basis, even if limited to claims-based measures for a period of time. Looking at data more frequently than annually or bi-annually allows RCCOs and providers to monitor whether their performance

improvement strategies are working and make adjustments along the way. We recommend that the Department do one of the following:

- Look into options for PCMPs and other providers to supplement claims based data with their own data sets, which offer stronger supporting data that paints a more complete picture
- If only claims data is being utilized, set the target goal lower to account for the gaps and limitations with claims data

74) Incentive payment frequency. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☒

If you checked the "Other" box, please describe payment frequency below:

Incentive payments are currently distributed quarterly to PCMPs and RCCOs. Quarterly is appropriate for the amount of money distributed as incentive payments. However, if a greater percentage of total compensation for RCCOs and PCMPs is distributed through incentive payments, then a monthly distribution frequency may be more appropriate to accommodate business cash flow necessities.

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

A RCCO can expect to incur fixed costs related to occupancy, furniture, equipment and the related technology licenses, insurance, and professional fees.

The largest annual fixed costs typically arise from the occupancy of the business location from which the RCCO operates. Physical space requirements can depend on the size of the required staff. Occupancy costs include rent, utilities, maintenance, and frequently property tax. In addition to the physical space requirements, office space requires furniture. The business and staff require technology based equipment and the related technology licenses. This fixed cost has a high obsolescence rate. General operating insurance is also a required element of operating a RCCO. Policies are typically administered on an annual basis, and the cost has a direct correlation with the industry, required coverage, and the history of the business.

Additionally, a RCCO will be required to prepare accounting records and annual tax reporting, address legal matters, administer information technology and processes that are HIPPA compliant, develop and maintain communication with the community, and manage the hiring and governance of competent staff. Each of these functional areas can be outsourced on a professional consulting basis. However, with a relevant staff size, economies of scale make hiring staff to fill these roles and control costs a preferred option.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Not applicable for a RCCO respondent.

Health Information Technology (HIT)

77) Types of communication. For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call/phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

This question is not applicable for a RCCO respondent.

78) HIT investments by organizations. For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☒	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☒	☐
Practice assessment tools	☒	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☒	☐
Shared decision-making tools	☒	☐
Telemedicine software	☐	☒
Other:	☐	☐
Other:	☐	☐

79) Importance of technology by type. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☒	☐
Practice assessment tools	☐	☐	☐	☒	☐
Health risk assessment software	☐	☐	☐	☒	☐
Practice management tools (scheduling, billing)	☐	☐	☒	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☒	☐
Patient education wellness tools	☐	☐	☒	☐	☐
Provider/case manager directory	☐	☐	☐	☒	☐
Shared decision-making tools	☐	☐	☐	☒	☐
Telemedicine	☐	☒	☐	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Interoperability of data from disparate systems is the major barrier. The Health Information Exchange is currently limited to results delivery, which does not allow for provider-to-provider data exchange or communication. In cases where data is able to be exchanged, the lack of a master patient identifier makes it difficult to match patient information coming from these disparate systems. In addition, the high cost from electronic health record vendors will continue to be a barrier, especially for primary care practices, even as interoperability solutions are developed at a national and state level.

81) How can Health Information Technology support Behavioral Health Integration?

Behavioral health in particular lends itself to telemedicine solutions. Many clients would be more willing to address behavioral health needs if they could do so from the privacy of their own home or primary care physician's office. While co-location provides some access at PCMP offices, it can't be adopted network wide due to requirements of space and sometimes provider disinterest. Telemedicine can provide an alternative to the co-location model. However, in order to successfully expand utilization of telemedicine, Medicaid should publicly support one or more acceptable software platforms.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

The Statewide Data Analytics Contractor (SDAC) dashboard already has the information necessary to provide robust data analytics. The interface needs to be modified for ease of use and provider customization. The current dashboard setup can be daunting and needs to incorporate a more simple and friendly format. The dashboard should also play on the natural competitive nature of medical providers and incorporate a rating system of some kind that compares provider performance.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

CCHA does not recommend a shared care management tool but does support the idea of a central depository for data. Day-to-day operations of care coordination, including analysis and identification of potential clients for care coordination, care coordination activities (assessments, care plans), and internal care management improvement activities, should remain at a RCCO level. This allows ease of access and the flexibility to make changes and implement new ideas. However, we do support the idea of a bi-directional central depository where we are able to share our care coordination activities with other agencies as well as access data from other agencies.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

CCHA supports the idea of a shared population health management tool. This tool should be used to produce evidence-based population predictive modeling for proactive care coordination/disease management. In order for the tool to be helpful, it would need the functionality to capture data from multiple resources beyond claims (e.g., RCCO, SEP, CCB) and push data to the RCCO. The data provided to the RCCO would need to be easily accessed, and RCCOs would require the ability to manipulate the data for targeting client populations.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

A useful Medicaid provider directory would contain accurate information and be updated on a monthly basis. In addition to practice address and phone number, other pertinent information would include the following: whether the practice is accepting new Medicaid clients, languages, hours of operation, practitioner gender and designation, as well as information regarding ADA accessibility.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

In our experience, there are several ways that RCCOs can support PCMPs with accessing meaningful clinical data that can be utilized to continuously monitor and make improvements, including:

- Help practices take advantage of Meaningful Use financial incentives to implement an electronic health records system
- Hire quality improvement coaches to help practices create systems, templates and flow sheets for discrete data capturing

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

Health Information Exchange (HIE):
The HIE allows for exchange of patient level clinical data across the continuum of care including bi-directional exchange from both provider EHR systems as well as facility EHR systems via standard formats such as the CCD-A. A solution is needed to overcome barriers that limit substance abuse and mental health information to create a complete record when appropriate.

Functionality for patient matching and census delivery to RCCOs is important. Admit, Discharge, Transfer (ADT) alerts from the facilities connected to the HIE need to be matched to a patient record and delivered to the RCCO managing care for the patient in real time. In order to accomplish patient matching, a Master Patient Index needs to be created and incorporated into HIE technology.

Patient Portal:
Patient portals provide clients the ability to view and download their personal health information including patient education, clinical summary of visits, and lab results. This option opens up an avenue of communication between clients and their care team as appropriate. An assessment of the population's ability to access the internet would need to be completed and communications options would need to be limited to appropriate topics.

Population Health/Gaps in Care Tools:
These tools offer near real-time, updated information for practice performance on quality measures, as well as provider level performance data. They allow for patient drill down and provide actionable data at the point of care as the client is being seen.

Risk Stratification - Predictive Modeling:
Risk stratification/predictive modeling tools help providers and their care team identify which clients are high risk today (eliminate claims data lag as much as possible by leveraging HIE clinical data) based on several factors such as ER admits, readmits, number of conditions, behavioral health, etc. These tools help providers and RCCOs predict which clients are not yet on the high risk list but have a high probability of making the high risk list in the near future.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

Efforts should be made to leverage or model a solution similar to the Centers for Medicare & Medicaid Services Blue Button Initiative to allow clients to access their own health information. Technical assistance should be supplied to help practices leverage their EHR technology, much like the Regional Extension Center program but with a slightly different focus on population health management, reporting, patient portal, and interoperability.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

Health Information Exchange platforms should remain intensely focused on the HIE to move beyond results delivery. Without a robust exchange of information, it is impossible to leverage population health and analytic tools across the ACC.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

The patient profiler on the Statewide Data Analytics Contractor (SDAC) dashboard has the potential of functioning as a statewide electronic client health record. Though the information is not a complete picture of the client's needs, it does provide a great amount of detail. The Department should capitalize on this and adapt the format to mimic an electronic health record as much as possible.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 064

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Mountainland Pediatrics
Location: Thornton, Adams County, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Community Reach Center
Location: Thornton, Adams County, CO
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Pediatrics
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☒ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
MLP is a contracted PCMH and is a delegated practice. We participate in all RCCO meetings.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
We accept Medicaid

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☒ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now? Number of patients who are attributed is high

   Reimbursement for PMPM is quick and allows us to support our patients with things that are not billable in a fee for service system.

   It is nice that they added a KPI that captures a pediatric measure.

   CORHIO is making it possible to know when one of our patients goes to the ED which allows us to follow up with them and schedule them with an out of hospital appointment.

   Nice focus on post-partum mothers and being reimbursed for screening.

2) What is not working well in the ACC Program?

   - Often get adults attributed to our pediatric practice and then we have difficulty getting them removed from our attribution. This effects our KPI's as adults tend to use more expensive services.
   - Denver Health patients are a challenge when they show up at our office wanting services as we will not get reimbursed for the services we provide.
   - The KPI of reducing ED use is not really within the control of the practice. When emergency rooms are advertising a 10 min wait and there is no disincentive for a patient to go to the ED, it is hard for us to impact that metric. Until the ED's are part of the solution, we will have a hard time impacting that metric.
   - The KPI for Well Child Checks – great idea, but is difficult to manage due to inaccurate contact information for parents. We often get newly attributed patients who are new to us and we try to reach out and invite the parent to bring the child in for a Well Child Check. Unfortunately, there is a high rate of being unable to contact parents due to inaccurate contact information.
   - SDAC data does not provide real time data, so it is difficult to impact the KPI's using that data.
   - Making the KPI's dependent on the region achieving them is not a good incentive and does not reward high performing practices.
   - The Medicaid population tends to be transitory, so they change practices frequently. It is difficult to be held accountable to the KPI's for a patient we never saw and was only attributed to us for a short period of time. It would be nice to base our KPI's on patients we have had on our rolls for a period of time (e.g. a quarter).
   - The RCCO's and BHO's don't align and don't necessarily have similar goals or accountability.

- No payment structure for doing integrated care.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

The BHO system has a good geographic coverage and allows for the provision of treatment for a wide range of disorders. The integration of care makes good sense and works well for these patients.

4) What is not working well in the BHO system?

- When there is a Behavioral Health Provider as part of the practice there are not easy systems for reimbursement for their services. For example, HCPF does not recognize the behavioral health codes within the primary care setting which would allow for services to be billed for patients who don't have a mental health diagnosis, but still need services (e.g. obesity).

- When providing short term behavioral interventions the mental health required paperwork makes it an inefficient process. Completing an in-depth intake, a CCAR and other documentation required by the mental health system does not work when the patient may only need one to two encounters that could be 20 min long for each.

- Sharing information between mental health and physical health continues to experience barriers – the mental health side wants a release of information to be signed before releasing necessary information.

- Poor communication between physical health and mental health

5) What is working well with RCCO and BHO collaboration right now?

Communication is beginning to open up and the sharing of high utilizer data is happening. This has allowed the CMHC's to support the effort on lowering the cost of care while improving outcomes.

6) What is not working well with RCCO and BHO collaboration right now?

The two systems need better communication and alignment of goals as well as policies and procedures. Outcomes will continue to suffer if the two systems are not communicating well and working well together. It is often the high utilizers who are involved in both systems.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- Payment that supports integrated care and a focus on prevention/early intervention

- Systems that allow for easy communication

- Data collection between the 2 systems that can show good outcomes

[1] Many terms and definitions can be found in the Appendix at the end of this document.

- Consistency around care management – currently a patient can and does have care coordination in both systems

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	Have to have a mental health diagnosis in order to get services – that is not always true in a primary care setting
Community Behavioral Health Services Rule	☒	☐	Mental Health require more intensive documentation that is not realistic when a patient will be seen 1-2 times
Covered diagnoses list	☒	☐	Capitation does not cover autism spectrum disorders
Different behavioral / physical health reimbursement	☒	☐	Mental health does not cover diagnoses such as obesity
Institutions for Mental Diseases exclusion	☐	☒	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	OBH requires more documentation that does not work in a primary care setting; No capacity to bill for services that are not based on a DSM diagnosis
PCMP financing structure	☐	☒	
Per-member per-month amount	☐	☒	
Physical space constraints	☒	☐	
Privacy Laws (HIPAA, 42 CFR)	☒	☐	42 CFR makes it difficult to share information readily from mental health to physical health
Professional / cultural divisions	☒	☐	All professions need to learn to work together in an integrated manner – both professions are focused on seeing as many patients as possible to maximize billing and that does not leave time to talk to each other
RCCO or BHO contracts	☒	☐	Goals, incentives and policies do not align
Staff capacity	☒	☐	Work force lacks adequate number of people to hire
State/Federal rules or reporting requirements	☒	☐	Reporting is based on having 2 separate models, not an integrated one

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Technical resources / data sharing	☒	☐	No structure in place to share data
Training	☒	☐	Both systems are trained in an insular manner – there needs to be cross training
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

- Allow for the use of behavioral health codes
- Eliminate need for in depth documentation (CCAR etc.) in primary care setting
- Take down barriers to sharing information
- Create structures that allow for data sharing and shared goals around outcomes for patients
- Set up a payment structure that is amenable to an integrated care setting and that is clear to practices providing such care
- Make regulations reasonable so they don't become a burden and increase cost of care or the amount of time spent meeting requirements.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

It will take systems changes in order to effect change in how services are provided and paid for. This is the opportunity to effect such a change.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

Treating the whole person to support the healthiest life style as possible. Addressing all needs of the person, regardless of type of need (medical vs. non-medical).

b. How should RCCOs prioritize who receives care coordination first?

They should work with the practices who know their patients and their needs to define who is prioritized.

c. How should RCCOs identify clients and families who need care coordination?

Practices need access to data, not only the SDAC, but internal data from their EHR that allows them to identify needs based on population characteristics (can identify patients based on diagnosis – diabetes, asthma) and through the use of registries.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

The practice should be responsible for reporting the number of patients with a care plan, number of contacts in a month, number of employees providing the care.

12) What services should be coordinated and are there services that should not be a part of care coordination?

Practices should work with other entities to be sure that all needs are covered – e.g. housing, benefits etc. The practice should not be responsible for the service specifically, but should be responsible to link patients to organizations that can meet the need.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

Diagnoses, systems they are already in, unmet needs to be addressed in order to be successful.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

Medical, Mental Health, Nursing homes, Health Departments, Housing Authority

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

Lots of coordination takes place outside and is usually focused on needs such as housing, benefits, child care etc. Those organizations don't usually reach out to the medical provider to let them know what coordination is happening and most medical practices who are providing coordination don't reach out to those organizations.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

Work with medical providers to ask more questions and to reach out to other organizations providing coordination. Provide training and outreach to non-medical organizations to facilitate better coordination.

d. What are the gaps in care coordination across the continuum of care?

There are gaps in specific services for the high utilizers, so when care coordinators try to find resources, there are none available.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	Should the RCCO have a role? No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☒	☒	
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	
Daycare / childcare	☐	☒	☒	
Economic stability & employment	☐	☒	☒	
Education	☒	☐	☒	
Environment	☐	☒	☒	
Food access / nutrition	☒	☐	☒	
Health literacy	☒	☐	☒	
Housing	☐	☒	☒	
Language or translation services	☒	☐	☒	
Literacy	☐	☒	☒	
Transportation	☒	☐	☒	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	Work with other professionals and lay persons involved in the case
Certified Addiction Councilors	☒	☐	""
Certified Nurse Midwives	☒	☐	""
Community Health Workers	☒	☐	""
Generalists (BA/BS/MA/MS)	☒	☐	""
Health Coaches	☒	☐	""
Licensed Clinical Social Workers	☒	☐	""
Licensed Marriage and Family Therapist	☒	☐	""
Licensed Mental Health Counselors	☒	☐	""
Licensed Professional Counselor	☒	☐	""
Masters of Public Health	☒	☐	""
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	""
Nurse Practitioners	☒	☐	""
Patient Navigators	☒	☐	""
Peer Advocates	☒	☐	""
Promotoras	☐	☒	
Psychiatrists	☒	☐	""
Psychologists	☒	☐	""
Registered Nurses	☒	☐	""
Social Workers	☒	☐	""
Wraparound facilitators	☒	☐	""
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☒	
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☐	☒	
Children involved in the foster care system	☒	☐	
Children with a chronic illness	☒	☐	
Children with a serious emotional disturbance	☒	☐	
Children with medical complexity	☒	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	
Transition-age adolescents	☒	☐	
Parents and families	☐	☒	
Pregnant women	☐	☒	
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☐	☒	
Adults with a chronic illness	☒	☐	
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	
Clients involved in the criminal justice system	☒	☐	
Clients with a disability	☒	☐	
Clients in a nursing facility	☒	☐	
Elderly clients	☒	☐	
Frail elderly clients	☒	☐	
Clients in palliative care	☒	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

Work with DHS to ensure that kids get the care they need; provide training for practices on managing the care of socially complex kids.

19) How should care coordination be evaluated? How should its outcomes be measured?

A care coordination program should initially be measure by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will be less likely to serve those with the highest risk.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

Based on a full time care coordinator that has an average case load of 500 the PMPM cost is between $8-$9 for that specific case load.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

t is not advisable to have the PMPM vary by specific population, please see 21.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

No, the RCCO should not set specific ratios. They should evaluate if outcomes are being met and should focus on helping practices improve processes for quality care. Mandating a ratio does not ensure quality care. The ratio will vary depending on the acuity level and needs of the patients and the practice is the best judge of what it takes to manage care.

a. **Care coordinator to client ratios**. If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☒
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

Care coordination should be measured in a way that does not burden the medical providers with intensive documentation and more time spent reporting measures than providing care. Ultimately, if care is coordinated you get better outcomes, so figure out a way to measure overall outcomes instead of counting every service that is provided. Also recognizing that outcomes for children are not as immediate as adults as much of what we do is prevention based. Prevention only shows up as an outcome when you are looking at them longitudinally.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Each practice should work with the RCCO to put a system in place to coordinate care. General guidelines can be helpful, but over-regulation makes it more expensive to provide the service and does not translate into better outcomes. Care coordination should be broadly defined and should include anything that adds value to the patient. One advantage of the current PMPM system is that it can be used by the practice to do whatever is helpful to the patient. Capitation was designed with this idea in mind, but over the years, more regulations were layered on top of the BHO's making it more difficult to use the dollars flexibly to support the needs of the patient. I would not like to see the RCCO's start layering on regulations and reporting requirements that become a burden and get in the way of good care. Most practices know how to provide good care and do so, despite barriers. RCCO's should work with practices to ensure quality care without over-regulation.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- The RCCO should work with medical practices to define QI functions and to set goals around achievement of those functions.
- RCCO's should provide more support in the attribution process and how to get wrongly attributed patients off the attribution list.
- RCCO's should meet on a regular basis with practices to review data and expectations and provide support around interventions to meet KPI's.
- RCCO's should share KPI performance across RCCO's and interventions that are working in other regions.
- RCCO's should be in communication with Emergency Departments to help manage ED use by patients.
- Streamline regulations and allow flexibility at the local level to achieve better care, higher quality, and lower costs.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

The RCCO should show what they are already doing to support practices in meeting their KPI's; and how they are working with other RCCO's to ensure standardization across regions.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

It would be nice if the RCCO regions and the BHO regions matched up

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

Standardize expectations across all regions

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

There is no benefit structure that supports integrated care. HCPF will not cover behavioral health codes and the BHO's require mental health level of documentation that is impractical. Funding needs to be flexible and able to support the needs of the patient. There is a need to move away from a fee for service model to a value based system where good outcomes are the focus.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

Having multiple RCCO's per region causes confusion and is not as efficient as one RCCO who has good relationships with community partners as well as the PCMH's.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

We accept Medicaid

34) What role should RCCOs play in attributing clients to their respective PCMPs?

They should help ensure that patients are assigned to the correct PCMP and help when there is a problem with attribution.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

They should work together to take down barriers to good care.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Work should be done to include private insurance as part of the ACC system. There are many services we can provide to Medicaid patients that we cannot provide for our insurance patients because it is not covered under their insurance.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

The RCCO should have an advisory board that includes patients.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

The RCCO should have an advisory board that includes these community partners.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

The achievement of good outcomes can only come through community engagement and buy in.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Through the PIAC's as well as some focus groups that engage community members as well as patients. It would be helpful to see what the end user is experiencing as working and not working.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

No

a. If no, what are the gaps?

It is difficult to find specialists in our community who will take Medicaid, due to lower reimbursement rates and higher no show rates.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

They have to become part of the solution as to the overuse of the ED's.

b. What role should pharmacies play in the next iteration of the ACC Program?

Communication around trends and problems they are experiencing.

c. What role should specialists play in the next iteration of the ACC Program?

We need to recruit more specialists to participate.

d. What role should home health play in the next iteration of the ACC Program?

They need to work closely with practices so care is coordinated and focused on good health outcomes.

e. What role should hospice care play in the next iteration of the ACC Program?

They need to work closely with practices so care is coordinated and the patient is supported during this transition.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

They need to understand and support the overall outcomes of the ACC's and coordinate their efforts to help us manage difficult populations.

h. What role should local public health agencies play in the next iteration of the ACC Program?

They are a good resource for population health and management – they have many lessons learned that can be shared. They also need to play a role in the management of difficult populations.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

Many of these organizations have valuable lessons learned and are very good at engaging difficult to engage populations. These organizations should be at the table to help us learn, but also to partner around the management of special needs populations.

45) How can RCCOs help to support clients and families in making and keeping appointments?

Education of patients and supporting practices when they are dismissing a patient for excessive no shows.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☒
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

Work with dental providers to understand their role in providing oral health care to this population. Include dental providers as part of the medical home network.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

Meeting the patient where they are at. Taking into consideration the things that influence their behavior and the way they need to get support.

b. What RCCO requirements would ensure cultural competency?

Focusing on good outcomes is the best measure. If your services are not culturally considerate of the patient then you will not get good outcomes.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

Good listening and engagement skills.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Having a staff that is reflective of the demographic make up of the practice would be helpful. Also recognizing that the health care work force is already unable to meet the demands, so when adding

cultural and language capacity as a requirement, it gets that much more difficult to meet the demand for services.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Engage hospitals and emergency rooms as partners in managing emergency room use. Currently they have a financial incentive to treat non-emergent issues in the emergency room.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

There are many examples of good networking (health departments, BHO's) that can be examples to learn from. The system has to get buy in across the communities if system reform is to happen.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☐	☒
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☒
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☒	☐	☐	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☒	☐	☐	☐
Provide registries	☒	☐	☐	☐
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☒	☐	☐	☐
Supply behavioral health surveys	☒	☐	☐	☐
Supply other self-screening tools	☒	☐	☐	☐
Administer behavioral health surveys	☐	☒	☐	☐

Administer other self-screening tools	☐	☒	☐	☐
Prepare client action plans	☐	☒	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☒	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☒	☐	☐	☐
Provide standing pharmacy order templates	☐	☒	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☒
Provide directory of other resources	☒	☐	☐	☒
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

Participation in QI projects; training for practices on models of efficiency; spreading knowledge learned in one region to other regions.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

KPI's that can be tracked and impacted.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

No – most practices already do this and the meaningful use requirement facilitates the use of the electronic health record to manage populations of patients

58) Please share any other advice or suggestions about provider support in the ACC.

Hire staff who have experience in the medical field and who understand a quality improvement process and how to facilitate a practice in taking on a QI process. Staff should also be comfortable with data and how data can be used to improve outcomes while reducing costs.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

The payment structure is set up for the region to meet their KPI's. There is no incentive for a practice that is meeting the KPI's because they will only get paid if the region makes it.

The incentive is low and does not offset the cost of managing high risk, high utilizing consumers. The system almost penalizes the practice for taking on these types of patients.

KPI's for children need to be included and need to focus on process outcomes as the payoff for managing their care well comes far in the future (e.g. getting the weight of an obese child under control potentially avoids all the adult chronic disease conditions that would occur if the obesity continued).

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

Our practice would be interested in receiving Capitated payments for our Well Child Visits. These visits include multiple services and having a capitated model would allow our provider the ability to concentrate on the patient and not on what requires an additional co-pay.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many practices have the capability and infrastructure to adapt to value based payment. It is the larger system of HCPF, RCCO's and BHO's that lack the infrastructure and access to real time data that is the barrier.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

We are not currently licensed by the DOI with an LSLPN, HMO or other license. We are a primary care practice and do not meet the definition of a LSLPN or HMO license.

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

From a primary care practice perspective because we are FFS I see no reason to change the role the RCCO has currently.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

Most practices have an electronic health record that is capable of tracking data and outcomes. HCPF and RCCO's should work directly with each practice to define a data set that will support showing outcomes.

Measures for children include Well Child Checks; screening at each Well Child Check; Follow up appointments for positive screens; Immunization records and screening for Post-Partum Depression.

Practices should submit patient satisfaction surveys and documentation of QI projects.

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☐	☐	
Focus groups	☒	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

Through data provided by practices from their EHR's

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

The RCCO's should work with practices to define the data that get at the triple aim.

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐

None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☒
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Yes

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Initially it should be based on improvement, with the goal of getting to national standards

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)?

This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☒
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

- Screenings and follow up visits
- Obesity measures (bmi, weight at each visit)
- Asthma measures (controller prescribed, safety plan given)
- Track referrals and follow through with the referrals
- Immunizations
- Well child checks
- We are reimbursed for some of the screenings we do, asthma consults, collecting biometrics for obese patients, immunizations and well child checks

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☒
Web portal	☐	☒
Email	☒	☐
Telemedicine / Video chat	☒	☐
Face-to-face meeting	☐	☒
Smartphone app	☒	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐

Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☒	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☒	☐
Care transitions alerts	☐	☐	☐	☒	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☒	☐	☐
Health risk assessment software	☐	☐	☐	☒	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☒
Patient education wellness tools	☐	☐	☐	☐	☒
Provider/case manager directory	☐	☐	☐	☐	☒
Shared decision-making tools	☐	☐	☐	☐	☒
Telemedicine	☒	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices? Everyone uses a different system and they don't readily communicate with each other.

81) How can Health Information Technology support Behavioral Health Integration?

Address the 42 CFR issue

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

What data practices are collecting, how they are using it to impact care and how they are measuring success towards the triple aim.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

The tool doesn't need to be exactly the same, but should capture some basic information such as: Need, Goal, Intervention and who will do it by when.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

Accurate and consistently updated list of providers and specialists who are currently accepting Medicaid patients.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

Develop relationships with practices and focus on QI projects and data that illustrates progress.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply?

This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 065

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Mindy Klowden
Location: Wheat Ridge, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Jefferson Center for Mental Health
Location: Wheat Ridge, CO
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Community Mental Health Center
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?
☒ Yes
☐ No

If you answered "yes" above, how long?
☒ 2-3 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Jefferson Center for Mental Health provides care coordination, under contract with the Region 6 RCCO CCHA and subcontract with MCPN, for patients whose primary diagnoses are behavioral health conditions. Jefferson Center also works closely with CCHA on the Jefferson County Hotspotting Alliance, and is in the process of obtaining PCMP status for the Union Square Health Home.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Jefferson Center is the community mental health center serving Jefferson, Gilpin and Clear Creek Counties since 1958. Medicaid is Jefferson Center's largest revenue source and approximately 50% of patients served by Jefferson Center have Medicaid, or qualify for Medicaid and we assist them in obtaining coverage. As a former MHASA, Jefferson Center has experience managing the care and bearing risk for persons with serious mental illness. We are also one of the owners/managing partners in Foothills Behavioral Health Partners, the BHO for our region.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?
☒ Reserved (waiting to see the RFP)

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

The ACC has been very successful in ensuring Medicaid members have a primary care medical provider and have access to care coordination. The ACC has also provided the state Medicaid program with the opportunity to take small but important steps towards value based payments, and to experiment with a global payment methodology through Rocky Mountain Health Plans' 1281 program. Another aspect of the ACC that is working well is the opportunity for stakeholder input, through the open meetings of the PIAC, stakeholder participation in the subcommittees, and opportunities to provide input to ACC staff through mechanisms such as this RFI.

2) What is not working well in the ACC Program?

The ACC program was developed originally with a focus on primary care, and integration of behavioral health and coordination with specialty care has been something of an afterthought. Behavioral health organizations and community mental health centers have been involved with RCCOs to a varying degree across the state, but are not managing partners or voting members in all regions. This means that the vast experience of BHOs and CMHCs in managing care, carrying risk and coordinating care for people with complex conditions has not been leveraged.

Secondly, while PCMP status may be granted to community mental health centers who meet the contracting requirements, this has happened inconsistently across the state. There is also regional variation in terms of how care coordination has been delegated, and this has resulted in some inefficient processes.

Another aspect of the ACC program that is not working well is that the incentives to providers are not significant enough to really make a difference in patient care. The Department took an important step forward in defining advanced primary care standards for PCMPs. These standards promote integration and align closely with the patient centered medical home standards. However the additional $.50 PMPM is not sufficient to incentivize practices in taking steps to achieve more patient centered care and invest in the infrastructure that may be necessary for population health management and integrated behavioral health services.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

The BHO system has been highly successful in achieving important benchmarks such as reducing hospital length of stay, hospital and ED utilization, and hospital recidivism among people with serious mental illness or serious emotional disturbances. While controlling costs per member, the BHOs have increased access to care. BHOs and community mental health centers have worked collaboratively to improve mental health functioning and overall functioning, reduce symptom severity, and contain costs to the state Medicaid program. Since 1996, BHO rates have increased at much slower rates when compared to other similar services, resulting in millions of dollars of likely savings for the state of Colorado.

Under the BHO system, community mental health centers like Jefferson Center have gained experience managing care for populations with complex health care needs and have successfully developed the clinical, administrative and technological capacities necessary to do population health management.

4) What is not working well in the BHO system?

Neither a total "carve-in" nor the current "carve-out" of behavioral healthcare services enables achievement of the "triple aim", or support integrated behavioral health and primary care. A total carve in would likely result in inferior care for people with serious mental illness, substance use disorders and children with serious emotional disturbances and in turn lead to increased hospitalization. A total carve in would also result in a loss of the 1915 (b) (3) Managed Care Waiver, which has allowed the state to control costs; in particular hospital costs would skyrocket. Prior to the carve-out, funding for behavioral health was constantly subject to cutbacks. A complete carve in may again mean that funding is not kept at an adequate level or that behavioral health providers are not given sufficient resources that are necessary to fully support patients in their recovery process, not just with their medical needs. However the existing carve-out does not fully support integrated, whole person health care. For example, primary care providers who are not part of the BHO network are not able to provide Medicaid members with fully integrated care. Community mental health centers, while supported through the carve-out for mental health and substance use disorder treatment, are not paid to provide behavioral medicine (addressing the behavioral aspects of physical health issues) or brief treatment for non-covered diagnoses (e.g. anxiety.) Some middle path may be required that both ensures an adequate level of behavioral health funding, and promotes whole person care. Ultimately, the ACC Program should consider moving toward a model where the RCCOs work with the BHOs - as equal partners- to assume and manage risk. In the short term, the 1915(b)(3) Managed Care Waiver has allowed the BHOs to bend the cost curve and must be kept in place as the state contemplates how it will bring together physical and behavioral healthcare in the future. The RCCO RFP should reward bidders who can integrate clinical care, data, and financing.

5) What is working well with RCCO and BHO collaboration right now?

The most recent BHO procurement process required that bidders include a detailed description of how the BHO would promote integrated behavioral health and primary care, and how the BHO would coordinate care with the RCCO. While much of this work was happening already, the contracting requirements helped to crystalize plans for collaboration. For example, FBHP formed an "Integration Collaborative" which includes representatives from Jefferson Center, Mental Health Partners, Arapahoe House, CCHA, and FBHP. The collaborative meets bimonthly to monitor integration activities, jointly problem solve and identify opportunities to expand and enhance integrated care in multiple clinic settings.

6) What is not working well with RCCO and BHO collaboration right now?

There is regional variation in the extent to which RCCOs and BHOs collaborate. In some communities, BHOs and community mental health centers are voting members of the RCCO boards, or even helped to develop/form the RCCO. In other communities, the BHOs and community mental health centers have worked diligently to collaborate with the RCCO but have no formal power or influence. The RCCOs have not all been able to use or interested in learning from the BHO's experience with successfully carrying risk and managing care.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Jefferson Center has served the community since 1958 and is considered a leader and early adopter in integrated behavioral health and primary care. We offer services that range from facilitated referrals to co-located behavioral health, to more fully integrated services. Our partners include 14 private community practices, 3 school based health centers, and 2 federally qualified health centers. One of our clinics, the Union 5quare Health Home, is a level 5 integrated health care home which offers psychiatric and mental health treatment, substance use disorder treatment, primary care, wellness services, and peer health coaching all under one roof.

Currently, community mental health centers that have achieved bi-directional integration, including Jefferson Center, are heavily reliant on grant funding. Typically, CMHCs are using capitated payments (from Medicaid, managed through the BHO) or FFS billing to commercial payors to pay for behavioral health services. Primary care providers working with the CMHC are utilizing separate FF5 billing or enhanced (per diem) payments to FQHCs. This is not a sustainable model, and has greatly hindered innovation and higher levels of integration. Time-limited grants such as the federal Primary Behavioral Health Care Integration program or local foundation funds have been used to fill in the holes, which are many. There is currently no ongoing, sustainable reimbursement available for the core services that truly make for a health home serving the SMI population including care coordination, wellness services, peer support, health coaching, and data collection.

On the primary care side, behavioral health providers are not able to bill for behavioral medicine, brief therapy (traditional mental health treatment is billable in 45-60 minute increments), or treatment of non-covered diagnoses (e.g. relational issues, grief and bereavement.) Current payment methodologies also do not support provider to provider consultation or time spent on collaborative care planning.

Efforts to promote healthcare integration through the ACC should coincide with the 5tate Innovation Model plan (5IM). As a state, we must seek multi-payer alignment on payment methodologies, key performance measures and integration principles.

Jefferson Center would like to suggest a few concrete steps that should be taken to promote behavioral health integration:

1. **Pilot an integrated behavioral and primary care global/bundled payment**

We are fortunate to have a very long history of working closely with Metro Community Provider Network, and have many shared patients with co-morbid conditions. We would like to have the opportunity to build on the work we have done at Union 5quare and other settings to offer whole person care. For an appropriate subset of patients (e.g. those with multiple chronic conditions including serious mental illness) a global budget or bundled case rate would help facilitate the appropriate level of care needed. This would support population health management, allow for the necessary resources to address chronic conditions, offer a higher level of care coordination and health education, and support provider to provider

[1] Many terms and definitions can be found in the Appendix at the end of this document.

consultation. As a former MHASA and part owner of FBHP, Jefferson Center is experienced with managed care and prepared to take on risk. We would like to see opportunity in the next round of RCCO contracts for the RCCOs to facilitate and support such a pilot. To achieve global or bundled payments, it may require funds be pulled from the ACC, the BHOs, and the Medicaid FFS/FQHC prospective payment system. This payment methodology would enable flexibility to proactively meet patients' needs, without the constraints of volume-based payments and separate billing for "behavioral health" vs. "physical health". It would support integration at the clinical, financial, and operational levels, and put physical and behavioral health on par.

We recognize that there are regional differences among the RCCOs as well as among providers, and that the strength of integration partnerships may vary from community to community. However there may be other communities where community mental health centers and FQHCs are ready for this kind of a pilot. The RCCO RFP should be written in such a way that it allows for the development of a pilot or pilots in which the RCCO's role is to support and encourage the pilot, but not to manage the funds or be directly involved in care delivery. The learnings from these pilots would be very valuable and we would fully participate in evaluation, dissemination and technical assistance to other communities in Colorado or even the nation at large.

2. **Support the development of integrated health homes within community mental health centers**
Persons with serious mental illness (SMI) die, on average 25 years earlier than the general population, with the average age of death being 53. (NASMPHD, 2006) The higher mortality rate is even more acute for persons with co-occurring substance use disorders; average age of death = 45) (Mauer, 2010.) This is largely due to preventable conditions. National research has found that people with SMI are more likely to have high blood pressure, metabolic disorders, asthma, stroke and other risk factors compared to people without SMI. Many of these health conditions are exacerbated by unhealthy practices such as inadequate physical activity, poor nutrition, smoking, and by the side effects of psychotropic medication. These health conditions are preventable through routine health promotion activities, primary care screening, monitoring, and chronic disease management. Yet people with SMI often lack access to adequate and coordinated health care, and are twice as likely to delay seeking medical care. Many individuals with SMI rely on emergency departments as a primary source of care, which results in avoidable expense and poor continuity in treatment of chronic conditions.

This underscores the importance of developing an integrated health home within the community mental health center setting to reach persons with SMI and/or SUD. CMHCs are highly experienced with population health, chronic disease management, and assisting patients in accessing and navigating needed community resources and social supports.

One example of this is Union Square Health Home (USHH), developed by Jefferson Center along with our partners at MCPN and Arapahoe House as a long term health care home for adults with serious mental illness in Jefferson County who previously lacked primary care. USHH offers psychiatric and mental health treatment, SUD treatment, primary care, wellness services, and peer health coaching all under one roof. USHH is a community-based solution to addressing a fragmented, poorly coordinated health care delivery system. By ensuring that adults living with SMI and other chronic conditions have access to integrated primary and preventive care, patients are diverted from inappropriate and more costly care settings such as the hospital emergency department

Preliminary outcomes indicate positive trends in wellness measures such as functioning in everyday life and staying socially connected, as well as physical health indicators including BMI, cholesterol, and blood glucose levels. One area where significant reduction in at-risk patients was seen was for metabolic syndrome. Metabolic syndrome is a group of indicators considered together, including blood pressure combined, waist circumference, plasma glucose, HDL cholesterol and triglycerides. Patients at-risk for three or more are positive for metabolic syndrome. At baseline patients averaged 1.5 at risk areas. That decreased to 1.2 at risk areas at 6-months ($t=3.2$, $df=146$, $p<.05$). Overall 25% of all patients were at-risk for three or more of those indicators at baseline and 12.2% at 6months. At the 6-month point in time 83.5% percent of patients were no longer at-risk (20.9% of all clients). Patient satisfaction is also high.

The development of bi-directional health homes was discussed in Colorado's SIM proposal, and we along with CBHC have advocated that the Department seek the 2703 Medicaid waiver to develop health homes for persons with chronic conditions. One way to ensure these efforts are aligned with the ACC would be if the RCCOs were directed to help identify patients with a SMI or SUD diagnoses who are not currently attributed to a PCMP, and connect them to the CMHC based health homes in their region. Recognition of CMHCs as PCMPs in the ACC is also critical.

3. **Open up the 9600 series health and behavior codes in Medicaid.** While the state should work towards payment reform, with global/bundled payments as the ultimate goal, an important interim step that should be taken immediately is to allow for billing under the Health and Behavioral Assessment CPT codes. These may be used to bill for services provided to clients who do not have a psychiatric diagnosis, but whose behavioral function impacts a health problem. There are 6 different codes that fall under this category and include health and behavior assessment, reassessment, brief intervention (15 minutes) with the individual, brief intervention in a group setting, brief intervention with the family and the patient, and brief intervention with the family but without the patient. These are important services that in many cases community mental health centers are already providing in FQHCs and other primary care settings, but are not being reimbursed for.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	Barrier? No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	See previous comments
Community Behavioral Health Services Rule	☐	☒	
Covered diagnoses list	☒	☐	Currently community mental health centers are not reimbursed for care provided to persons with non-covered diagnoses such as PTSD, situational depression and anxiety. Yet these diagnoses are common among patients being seen in primary care settings.
Different behavioral / physical health reimbursement	☒	☐	See previous comments
Institutions for Mental Diseases exclusion	☒	☐	This is an archaic requirement that is a barrier not only to integration, but to access to needed in-patient care. The institutes (Ft. Logan and Pueblo) are made responsible for all medical expenses for patients that are admitted. So, if a patient has medical issues such as a pregnant woman, patient with sleep apnea or a chronic condition, the institutes may not accept them for in-patient care. They have been forced to be rigid in their acceptance criteria out of necessity to contain costs. The solution is to continue Medicaid payments for patients hospitalized at the institutions.
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	OBH and HCPF should continue to work together to align policies, reduce administrative burden on providers, and eliminate funding silos to support comprehensive care and population health objectives. Specific to integrated care, OBH should relax requirements around the CCAR for patients served in integrated/primary care settings.
PCMP financing structure	☒	☐	The current PCMP financing structure is not sufficient to incentivize practices in taking steps to achieve more patient centered care and invest in the infrastructure that may be necessary for population health management and integrated

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

			behavioral health services. For the long term, the ACC should pursue a global/bundled payment methodology that eliminates FFS completely and more fully supports integration. In the short term, the department may need to increase the PMPM payments.
Per-member per-month amount	☒	☐	See above comment.
Physical space constraints	☒	☐	Whether integrating behavioral health services into primary care, or primary care services into community mental health center settings, some modifications are required for clinics to support integrated care. In primary care, there may be the need for additional exam rooms or offices to allow for behavioral health treatment to occur with privacy. Rooms may be required for group treatment or group visits as well. In community mental health centers, physical modifications will be required to transform space previously used for individual, family and group psychotherapy into medical exam rooms. CMHCs will need to ensure that there is adequate equipment, refrigeration (e.g. for vaccinations), sinks, areas for labs and basic medical procedures. IT infrastructures that are necessary to support integration in any setting include disease registries and other population health management tools that are built into EHRs; technology that supports sophisticated data collection and reporting; and technology and systems required to facilitate health information exchange (such as through exchange of Continuity of Care documents). Consistent with SIM, the state should invest in infrastructure development and offer time limited grants that provide start-up funds to clinics who are ready to implement integrated care.
Privacy Laws (HIPAA, 42 CFR)	☒	☐	Community mental health centers routinely request releases of information and do not often encounter patients who are not willing to sign an ROI. However, ROI requirements of 42 CFR Part 2 make the electronic sharing of information/health information exchange very complicated. Currently, CORHIO does not have the technical capabilities to support tiered consent. This means that providers who want to do collaborative care planning are forced to do duplicate data entry and/or invest in technology that supports the exchange of continuity of care

			documents – which is useful but does not really allow for integrated treatment plans.
Professional / cultural divisions	☒	☐	The "cultural differences" between primary care and behavioral health are numerous. The ACC's role in addressing these divisions/siloes should be consistent with the State Innovation Model plan- to invest in practice transformation support and training.
RCCO or BHO contracts	☒	☐	See previous comments under general questions 1-6.
Staff capacity	☒	☐	The ACC's role in addressing staff capacity needs should be consistent with the State Innovation Model plan- to invest in practice transformation support and training.
State/Federal rules or reporting requirements	☒	☐	The CCAR/DACODS is an administrative burden on clinicians, particularly behavioral health professionals working in primary care settings. OBH and HCPF should work collaboratively to develop an amended/shortened tool.
Technical resources / data sharing	☒	☐	See comments under privacy laws.
Training	☒	☐	The ACC's role in addressing training needs should be consistent with the State Innovation Model plan- to invest in practice transformation support and training.
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

The State should recognize that integration of physical and behavioral health occurs along a continuum and there are advantages and disadvantages to each level of that continuum. Each practice needs to evaluate the needs of its patient population, the strengths and weaknesses of its infrastructure, and both its long term vision for integration and what is realistic in the short term. Co-located services increase access to care, begin to promote collaboration across providers, and help mitigate stigma. More fully integrated services, which include routine collaboration among providers, shared care plans and population health measures may not be realistic for many providers until payment reform more fully supports integrated services. The state should promote partnerships between physical and behavioral health providers where appropriate in a community, and also support practices who want to move towards a fully integrated model by hiring providers directly.

The State should also work to align principles of healthcare integration across the RCCO, BHO and commercial insurance environments in order to achieve the goals of SIM.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Please see previous comments under "behavioral health integration".

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

The definition that resonates most with us comes from the Institute for Healthcare Improvement: http://www.ihi.org/resources/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx

"The care coordinator is the care provider responsible for identifying an individual's health goals and coordinating services and providers to meet those goals. Given the needs of the individual, the care coordinator may be a nurse care manager, social worker, community health worker, or lay person. Regardless of the credential, the care coordinator will have expertise in self-management and patient advocacy and will be adept at navigating complex systems and communicating with a range of people, from family members to doctors and specialists. It is the responsibility of this care coordinator to identify life and health goals with the individual and to coordinate services and community supports to work with the individual toward better health outcomes. All the while, the care coordinator keeps a current understanding of the strengths and gifts that the individual and family bring (their "assets"). At its essence, the care coordinator is the person responsible for ensuring that the care plan is carried out in partnership with the person at the center of the care plan."

b. How should RCCOs prioritize who receives care coordination first?

While all patients should have access to some basic care coordination services, those with multiple chronic conditions and complex social service needs (e.g. homelessness, unemployment) may require more intensive services. RCCOs and PCMPs need to use appropriate assessment tools to do risk stratification and ensure those patients at greatest risk are prioritized.

c. How should RCCOs identify clients and families who need care coordination?

RCCOs and PCMPs should use a combination of predictive modeling (based on claims data, history of ED/hospital utilization) and patient interview/assessment to determine clients and families in greatest need. The Patient Activation Measure is also useful in determining a patient's level of readiness to make change.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

Through data on key performance indicators and outputs (patients served, encounters, etc.)

12) What services should be coordinated and are there services that should not be a part of care coordination?

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

- History of trauma
- Employment and Housing History

- Hospital and ED utilization history
- History of SUD and/or mental health problems
- Patient Activation Measure score

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

    a. What care coordination is going on today?

    b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

Community mental health centers such as Jefferson Center use care managers and navigators to assist patients in navigating the health care and behavioral health delivery systems, accessing needed community resources and recovery supports. What makes this care coordination different is that it is focused equally on health and health care as it is on social determinants of health, and overall individual/family functioning.

In addition, in our integrated clinics Jefferson Center employs health care coordinators who work to ensure communication across providers, break down barriers to care and assist patients in scheduling appointments, and completing all necessary screenings and paperwork. We have been heavily reliant on grant funding to support care coordination, yet this is an essential component to successfully integrating care.

    c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

The RCCOs play a valuable role in offering care coordination for patients that cannot access those services at the point of care. However, there has been ample research that shows care coordination is most effective when it is delivered at the point of care. We would like to see the next RCCO RFP promote and encourage the delegation of care coordination services to providers who have proven capacity and expertise in this area.

For this to be most successful, particularly with individuals with multiple chronic conditions, an increased PMPM or different payment methodology is required. Practices should have the flexibility they need to tier care coordination so that patients with more complex health care needs are offered more in depth services. An algorithm of care coordination should be used based on severity of physical and behavioral conditions. Community mental health centers are often the most appropriate care coordination provider for those patients who see the mental health center as their health care home. Consequently the department should directly encourage RCCOs to contract with community mental health centers as PCMPs and/or to delegate care coordination functions to CMHCs in the next RFP.

    d. What are the gaps in care coordination across the continuum of care?

Many health care providers do not have strong relationships with human service agencies and community based organizations. This is another strength community mental health centers bring to the table.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role?	Should the RCCOs coordinate with community	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?

	Yes	No	supports and services? Yes	
Abuse, neglect, and trauma	☒	☐	☒	Support screening at the provider level; augment where necessary. Ensure access to appropriate treatment services when trauma is indicated.
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	Support at the provider level; augment where necessary.
Daycare / childcare	☒	☐	☒	
Economic stability & employment	☒	☐	☒	
Education	☒	☐	☒	
Environment	☒	☐	☒	
Food access / nutrition	☒	☐	☒	
Health literacy	☒	☐	☒	Support health coaching and patient education at the provider level; augment where necessary.
Housing	☒	☐	☒	
Language or translation services	☒	☐	☒	Support at the provider level; augment where necessary. Ensure language competencies within provider network.
Literacy	☒	☐	☒	
Transportation	☒	☐	☒	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☒	
Certified Addiction Councilors	☒	☐	
Certified Nurse Midwives	☐	☒	
Community Health Workers	☒	☐	
Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☒	☐	
Licensed Mental Health Counselors	☒	☐	
Licensed Professional Counselor	☒	☐	
Masters of Public Health	☒	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☒	
Nurse Practitioners	☐	☒	
Patient Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☒	☐	
Psychiatrists	☐	☒	
Psychologists	☐	☒	
Registered Nurses	☒	☐	
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	
Other	Please type your response here. Responses above are driven by concern for providing appropriate care while containing cost- it would not be efficient to use a professional with credentials such as anMD, PhD, PsyD, APN, NP or PA to offer care coordination services.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☐	
Children	☒	☐	
Children who are healthy, but in socially-complex environments	☒	☐	
Children involved in the foster care system	☒	☐	
Children with a chronic illness	☒	☐	
Children with a serious emotional disturbance	☒	☐	
Children with medical complexity	☒	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	
Transition-age adolescents	☒	☐	
Parents and families	☒	☐	
Pregnant women	☒	☐	
Adults	☒	☐	
Adults who are healthy, but in socially-complex situations	☒	☐	
Adults with a chronic illness	☒	☐	
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	
Clients involved in the criminal justice system	☒	☐	
Clients with a disability	☒	☐	
Clients in a nursing facility	☒	☐	
Elderly clients	☒	☐	
Frail elderly clients	☒	☐	
Clients in palliative care	☒	☐	
Other populations, please comment: All populations should be given individualized, patient-centered care. Care coordination should be tailored to the needs of the individual and family. With that said, some populations will require more intensive services than others. Risk stratification should be used systematically.			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

Care coordination metrics should be designed to reflect the triple aim of improved population health, improved patient experience of care, and reduced overall health care costs.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

The RCCOs play a valuable role in offering care coordination for patients that cannot access those services at the point of care. However, there has been ample research that shows care coordination is most effective when it is delivered at the point of care. We would like to see the next RCCO RFP promote and encourage the delegation of care coordination services to providers who have proven capacity and expertise in this area.

For this to be most successful, particularly with individuals with multiple chronic conditions, an increased PMPM or different payment methodology is required. Practices should have the flexibility they need to tier care coordination so that patients with more complex health care needs are offered more in depth services. An algorithm of care coordination should be used based on severity of physical and behavioral conditions. Community mental health centers are often the most appropriate care coordination provider for those patients who see the mental health center as their health care home. Consequently the department should directly encourage RCCOs to contract with community mental health centers as PCMPs and/or to delegate care coordination functions to CMHCs in the next RFP.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

While some flexibility is required to meet the unique needs of each local community, some uniformity across the state is necessary to ensure the ACC program as a whole is achieving the Triple Aim. The RCCOs should be required to adhere to a uniform set of guidelines in terms of contracting with PCMPs, collaborating with BHOs and community mental health centers, collaborating with safety net medical providers, sharing risk with providers, data reporting and reaching key performance indicators. RCCOs should be encouraged to delegate care coordination activities at the point of care whenever providers have the capacity and proven experience. The ACC should also encourage RCCOs and PCMPs to invest in technology (e.g. medical records, health information exchange, use of disease registries.)

Regional variation should be allowed in terms of approved pilot projects, which may include different payment methodologies in the short term such as the 1281 pilot or the provider-level global/bundled payment pilot suggested in this paper between Jefferson Center and MCPN. It also makes sense to allow regional variation in the approach RCCOs take in providing training/practice transformation support.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

RCCOs should have representation from BHOs, Community Mental Health Centers, human service organizations on their governing and advisory boards.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This proposal makes some sense from the perspective of large providers and FQHCs whose service boundaries cross multiple RCCO regions. Aligning with one RCCO could reduce administrative burden on providers. This should be considered with the caveat that the PATIENT should be given a voice in how they are enrolled and attributed.

27) Should the RCCO region maps change? Why or why not? If so, how?

The Department should re-evaluate the RCCO regions based on patient preferences and patterns of utilization. RCCO region maps should support naturally occurring medical neighborhoods.

28) Should the BHO region maps change? Why or why not? If so, how?

The BHOs and community mental health centers should be consulted in terms of how patients access care, what if any barriers exist currently, and if/how the map should be drawn to align RCCO and BHO regions. BHO maps should definitely align with community mental health center regions.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

There are several policy levers the state should use to maximize effectiveness not only of the ACC but of the Colorado Medicaid program overall. One state policy lever that should be utilized is the 2703 Medicaid waiver for Health Homes for Persons with Chronic Conditions. Colorado should submit a State Plan Amendment to allow for the creation of Health Homes in Medicaid that are based in community mental health centers and serve people with serious mental illness, substance use disorders, and/or one or more other chronic conditions. This effort should be done in tandem with SIM, to ensure payment and outcome metrics are aligned. RCCOs should then be directed to help identify patients with a SMI or SUD diagnoses who are not currently attributed to a PCMP, and connect them to the CMHC based health homes in their region.

The Department should seek authorization to pilot an integrated behavioral and primary care global/bundled payment, such as proposed in response to question 7 of this document. Bundled payments such as those proposed here will further support cross-systems integration provided behavioral health is an equal partner in the endeavor.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

While the Department offers continuous eligibility for children for 12 months, it does not have this in place for adults. Medicaid members who rely on seasonal employment (such as those working in resort communities) and those with complex social situations may experience fluctuations in income. Without continuous eligibility these patients are subject to churn and it is very challenging for providers to ensure continuity of care. The Department should change the benefit structure to prevent this from happening when possible.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

No, this would just cause confusion and be inefficient.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

N/A

34) What role should RCCOs play in attributing clients to their respective PCMPs?

As community mental health centers become PCMPs, RCCOs should work to ensure patients with SMI/SED diagnoses and multiple chronic conditions are attributed to health care homes where their needs can best be met.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

Prevention and population health management need to be a key function of RCCOs and PCMPs, so strong linkages with both CDPHE and local public health departments are important. The ACC program should promote strong awareness of CDPHE's winnable battles and prevention strategies.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

The ACC program, and the Department overall, should continue to work with CDHS/OBH to align policies, reduce administrative burden on providers, and eliminate funding silos to support comprehensive care and population health objectives. As more patients gain coverage through Medicaid expansion, the needs for OBH block grant and general fund dollars are changing. The agencies should work together, and involve stakeholders, in determining if and how these resources should be used differently. For example, there may be prevention and early intervention activities, services that address the social determinants of health, and other aspects of care that are not covered by Medicaid that OBH funds could be directed towards.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

We encourage continued collaboration on enrollment, retention and churn.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

The ACC should coordinate with the Division of Insurance to ensure adequate coverage for behavioral health in the commercial market. Commercial payors are beginning to expand their coverage for behavioral health due to parity legislation and the inclusion of mental health and substance use disorder treatment as 1 of 10 essential health benefits under in the Affordable Care Act. A key to integration is ensuring people who are on private insurance have the behavioral health coverage they need to get necessary prevention, early intervention and treatment. PCMPs and health homes established through SIM or the 2703 waiver may identify areas where coverage is inadequate or not in line with parity, and report this to The Division of Insurance who can inform and educate the insurance carrier about possible compliance issues and how they can remedy the situation.

Consider a license for integrated practices that streamlines regulatory processes and requirements between the physical health and behavioral health systems.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

Representation on the governing and/or advisory boards, patient experience of care surveys, and use of ombudsman/client advocates.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

Representation on the governing and/or advisory boards (this should include BHOs and CMHCs.)

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

Agendas and minutes from RCCO-level program advisory board meetings should be made available on the ACC website, just as PIAC meeting notes are.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

No

a. If no, what are the gaps?

Many community mental health centers are still not recognized as PCMPs, and specialists are not part of the ACC program at all. There continues to be a shortage of specialists that accept Medicaid, largely due to concerns over administrative burden and inadequate reimbursement. A Global or bundled payment methodology may enable the ACC to move into being more of an ACO model of care. "Healthcare neighborhoods" need to be supported.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

RCCOs could receive incentives for appropriate E.D. and inpatient utilization reductions. Hospitals should coordinate with RCCOs, BHOs, PCMPs and community mental health centers to develop health care neighborhoods and ensure strong care coordination designed to reduce inappropriate utilization patterns.

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

RCCOs, BHOs, PCMPs and community mental health centers should be included in the required planning for health departments and work to develop relationships and collaborations that support population health.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

This is an appropriate role for care coordinators, peers, patient navigators, etc.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

Community health workers, peers, health coaches, navigators can play beneficial roles in promoting health literacy and assisting patients in navigating systems of care. PCMPs should be provided adequate and flexible funding to utilize these cost-effective resources. The Department should not require the use of these positions without ensuring adequate funding is available to pay for their services.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☒
On staff (salary) at RCCO	☐

Per Member Per Month Payment	☒

Also- on staff at community mental health centers.

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

Oral health is a key component to overall health and RCCOs that facilitate coordination should be incentivized in some way, as should PCMPs that integrate oral health.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

The ability to provide health care services that are patient-centered and responsive to and individual's unique cultural, ethnic, linguistic and other characteristics.

b. What RCCO requirements would ensure cultural competency?

RCCOs should be required to demonstrate network adequacy in terms of cultural and linguistic competencies.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

Access to language line, translators, and/or multilingual staff

Materials written in very basic language (4th grade reading level)

Availability of health coaching, peer support, and/or patient navigation

Cultural competency training and organizational policies

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Same as above

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Several communities have efforts to address the needs of "super-utilizers". In addition to the ACC Super-utilizer project in RCCOs 4 and 7, there is the Bridges to Care Program in Aurora (funded by a CMMI grant) and

the Jefferson County Hotspotting Alliance, which Jefferson Center for Mental Health helped to form and actively participates in along with CCHA, MCPN, Arapahoe House, Lutheran Medical Center and St. Anthony's. Each of these programs utilizes an intervention which includes care coordination and patient education that is designed to reduce ER and hospital utilization by getting patients into primary care and/or behavioral health services. The ACC should promote cross-systems integration and support efforts such as these.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☐	☐	☒	☐
Provide health and functioning questionnaires	☐	☐	☒	☐
Provide chronic care templates	☒	☐	☐	☐
Provide registries	☒	☐	☐	☐
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☒	☐	☐	☐
Supply behavioral health surveys	☒	☐	☒	☐
Supply other self-screening tools	☒	☐	☐	☐
Administer behavioral health surveys	☒	☐	☒	☐
Administer other self-screening tools	☒	☐	☐	☐
Prepare client action plans	☒	☐	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☒	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐

Provide visit agendas or templates	☒	☐	☐	☐
Provide standing pharmacy order templates	☒	☐	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☐
Provide directory of other resources	☒	☐	☐	☐
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

SBIRT, PHQ 2/9, AUDIT, DAST, CRAFFT, SF 36, and some kind of trauma screening should be used.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

Practice transformation in the ACC should be aligned with practice transformation efforts under SIM. Adequate funding – well beyond the current $.50 offered to the advanced primary care practices- is needed to incentivize primary care medical home principles and behavioral health integration.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

Develop payment methodologies that are risk-based and fully support whole person, integrated and comprehensive care.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

Disease registries and other population health management tools should be incentivized, not required.

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

No. Payment methodologies that align with SIM, more fully support integrated care, and move beyond fee for service towards global/bundled payments are needed.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

"Primary care capitation" would not achieve whole-person care. Jefferson Center has proposed to work with our integration partner, MCPN, to take on risk and co-manage the care for a shared patient population. To achieve global or bundled payments, it may require funds be pulled from the ACC, the BHOs, and the Medicaid FFS/FQHC prospective payment system.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Some providers do and some do not. The required infrastructure includes population health management tools (such as disease registries with clinical decision making capabilities), electronic health records, QI expertise, and the ability to produce and analyze reports at both the population and the patient level. Practice transformation coaching/TA/training such as what is proposed in SIM will be required to prepare many practices for payment reform and behavioral health integration.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

Currently the Department pays PCMPs rather than the RCCOs. If the RCCOs were to take on this function, they would gain more "control" over the PCMP. While this may reduce administrative burden on the Department, it seems like it would signal the expectation that RCCOs become managed care entities. Not all RCCOs are experienced in bearing risk. This would be another example of the need to partner with and maximize the BHOs experience in effective utilization management, coordinating care and carrying risk.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	
SF-12 Health Survey	☒	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☒	☐	The PAM is an effective tool to gauge patient self-efficacy pre and post intervention. It also helps determine the level/intensity of intervention (e.g. coaching, education) and care coordination that is needed.
Focus groups	☒	☐	
Other	Please type your response here. Patient/family member participation in governing/advisory boards.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

Work with CDPHE to design an assessment methodology. Use community assessments such as those required of hospitals and local health departments.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐

51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☒
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Yes.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Both.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

N/A

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

BHOs evaluate and monitor community mental health centers on a variety of indicators as required by the Department. These include but are not limited to hospital length of stay, hospital and ED utilization, hospital recidivism among people with serious mental illness or serious emotional disturbances, access to care, and penetration rate. OBH evaluates and monitors community mental health centers using the CCAR/DACODS to track client progress on a number of domains including symptom severity, mental health functioning, overall functioning, etc. Jefferson Center does much more than the minimum required by HCPD and OBH. We have a Performance, Quality and Effectiveness department with skilled data analysts/evaluators on staff. We manage reporting for numerous federal, state and local government, and private foundation grants. We also collect qualitative data to measure patient experience of care and patient satisfaction.

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO: **N/A**

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☒	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☒	☐
Shared decision-making tools	☒	☐
Telemedicine software	☐	☒
Other: Smart phone apps for chronic disease management	☐	☒
Kiosks for client check in and screenings	☒	

Other: "My Strength" self-help platform	☒	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☒	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☒	☐	☐
Health risk assessment software	☐	☐	☒	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☒	☐	☐
Patient education wellness tools	☐	☐	☒	☐	☐
Provider/case manager directory	☐	☐	☒	☐	☐
Shared decision-making tools	☐	☐	☒	☐	☐
Telemedicine	☐	☐	☐	☒	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

The expense to providers and lack of interoperability across health care settings.

81) How can Health Information Technology support Behavioral Health Integration?

a) Tele-health may be a valuable tool for psychiatry and behavioral health interventions – this virtual integration may be most appropriate in rural communities or in small practices which do not have sufficient volume to support a co-located provider. Technology such as Project Echo may be essential to support provider to provider consultation.
b) We at Jefferson Center have been working with our integration partners at MCPN and Arapahoe House to try to achieve a private health information exchange that supports not only exchange of information around shared patients in integrated care settings but also clinical decision making and team based

care. We have spent several years and invested financial resources in searching for a platform that would connect our EHRs, and ultimately began working with CORHIO. However they do not currently have the technology to support tiered consent or data that can only be shared with the use of a signed release (required when SUD diagnoses and treatment are involved.) We are currently using continuity of care documents to exchange information as an interim solution but are hopeful CORHIO will identify or develop tiered consent in the future.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

This should include behavioral health data.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

CORHIO and QHN are facilitating much needed health information exchange across health care settings. They should continue to work towards integrating behavioral health data, getting all providers on board, and achieving tiered consent models to help work around the current barriers such as 42 CFR part 2.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

The ACC program should align efforts around HIT and HIE with those occurring under SIM.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 066

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

CommunityCare
CENTRAL COLORADO

Performance Improvement Advisory Committee (PIAC)
November 18, 2014
Meeting minutes

Roll Call:
Present: Dr. Fred Michel (AspenPointe), Dr. Michael Welch (Peak Vista Community Health Centers), Anita Rich (CCHAP), Meredith Roach (Community), April Plunk (Member), Agim Elshani (Member), Patricia Yeager (The Independence Center), Annette Fryman (Community Advocate), Dr. Greg Sharp (Ideal Family Healthcare)

Staff: Joe Farr, Allan Olipane, Ryan Smith, Terri Reishus, Kerri Tashjian, Dr. Joel Dickerman, and Kelley Vivian

The meeting was called to order at 5:30 p.m.

Agenda Item #1: Welcome and Introductions:
The Performance Improvement Advisory Committee introduced themselves and welcomed all participants.

Agenda Item #2: Charter, Membership and Meeting Schedule for 2015
PIAC members were thanked for their participation in 2014. A recap of highlights from the PIAC included retooling the member survey to get more actionable feedback from consumers and feedback on Community Care's pilot projects and programs.

Membership terms and the PAIC charter were reviewed. Members were reminded that service is voluntary and length of service is by calendar year. The committee reaffirmed desire to keep meetings at same day/time, same format, same frequency, and same terms of membership. PIAC members suggested ways for Community Care to broaden scope of participation by adding committees or committee members from different communities in the service geapgraphy and creating accessibility through technology.

Agenda Item #3: Request for Information (RFI): Stakeholder and Consumer Engagement for the Accountable Care Collaborative Discussion
The RFI released by the Department of Health Care Policy and Financing soliciting feedback on the next RFP for the Accountable Care Collaborative was discussed. The committee discussed the following numbered questions from the RFI regarding stakeholder and consumer engagement:

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

- What happened if a RCCO doesn't meet this requirement? Does it get penalized? How does the state ensure that the representation is really from the community? The state should require that RCCOs demonstrate their PIAC is representative of the community served, including by stakeholder group and by geography.
- RCCOs should better market their program to the community to encourage involvement. People can't join what they don't know about.
- PIAC committee should focus on more representation rather than limiting participation.
- More consumers and their families should be involved.
- There should be a requirement to get stakeholders and consumers engaged than just the PIAC. Surveys, comment drop boxes, and 21st century technology methods like social media should be included in requirements for stakeholder and consumer feedback.
- Consumer advocates are important as they can be the voice of those that can't participate (voice/advocacy) – kids, deaf and blind, etc.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

- Some of the same themes on education of RCCO from question 39.
- RCCOs should be required to put forth communication tool or mechanism that allows stakeholders to talk with each other about the system, this could be social media.
- RCCOs should encourage listening in for all PIAC meetings even if someone can't attend in person, livestreaming would help people listen and learn.
- RCCOs should not be prescriptive and should be right for their community – should not require "x number of providers", "x number of a specific member population" etc.
- PIACS should also assess themselves and their ability to create change in the system. What good are these meetings if we don't change the system for the better. Maybe local PIACS should report up to the state PIAC for information sharing.
- The state should require RCCOs to non-profit, community agencies. For profit companies won't engage stakeholders. Community involvement is key and private interests should not be involved (for profit entities that would want to bid on RCCO). The state needs to ensure communities use stakeholder engagement to make decisions. Local community involvement is essential ingredient. Should be responsive to partners and community and an outside partner would not necessarily do this.
- Require in RFP that RCCOs demonstrate a process that engages clients and providers and how this happens – the documentation for this would be letters of support from providers, consumer, and community agencies.

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Being able to communicate directly to RCCO staff and solve issues and interact with consumers.
- Local contacts are important.
- Member feedback: Telling provider I am in the RCCO provides for better service.

- Pilots – rapid cycle change are a great form engagement of stakeholders. Pilots create opportunity for stakeholder feedback and a way to interact with RCCOs.
- Communicate more broadly and target communication where people congregate (health fairs, etc.).

7) What should be the next steps in behavioral health integration in Colorado?

- More integration in one location to treat the entire person.
- BHOs service areas should line up with RCCOs.
- Bring services close to where patients are.
- Require cultural competency – shared information exchange.
- HIPAA & CFR42 are restrictive to integration.
- PIAC posed question: Should bidders be rewarded for a unified community-based communication system? Regions need to connect, but systems to be community relevant.

Agenda Item #4: Public Comment:
No public comment was offered.

The meeting was adjourned at 7:00 p.m.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 067

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

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THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Beth Ryan
Location: Denver, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: The Denver Hospice
Location: Denver, CO
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Palliative Care & Hospice
  ii. Area of practice: Palliative Care and Hospice
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☐ Yes
☒ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
We have tried and offered to be participants in the ACC. Open the doors to other providers. We hope that's the case. We are interested.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Provide services for Medicaid as allowed by the Hospice benefit.
Palliative Care is poorly reimbursed thus not currently a sustainable model.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

The Accountable Care Collaborative (ACA) seems to be doing well in reaching those clients that are available and already connected to systems.

2) What is not working well in the ACC Program?

It seems there's still a lot of work to do to reach those with high needs and at high risks. Those who are currently disenfranchised from systems and hard to reach (for a variety of reasons) are not being served. The ACC has not yet begun to touch the highest risk population.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

Behavioral organizations do well with compliant individuals.

4) What is not working well in the BHO system?

Finding new ways to find and work with the non-engaged populations that generate higher costs and are at higher risks that are not. We recommend looking at strategies that take behavioral health out of the office and institutional environment in which it currently operates, and implement strategies in community (neighborhoods, community organizations, home setting, etc) in order to serve this population.

5) What is working well with RCCO and BHO collaboration right now?

A good step in the right direction are the case managers who are connected to individuals and doing case coordination. We didn't have this before. Additionally, the attempts to reach-out to Medicaid and dual eligibility populations are also working well.

6) What is not working well with RCCO and BHO collaboration right now?

We are still not reaching the hard to reach populations; those that are not coming into clinics and systems of care.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

At The Denver Hospice, we believe that collaboration between Health Care (physical health) and Behavioral Health is critical to delivering holistic care coordination that improves the health and wellbeing of clients. We respectfully request that the ACC give serious and favorable consideration to the role that social workers play in health outcomes, and develop a reimbursement model that honors the health and financial contributions in-home social workers make to client outcomes and systems cost-savings.

For more than 20 years, the Denver Hospice has successfully integrated behavioral health with the physical care of our clients. Assembling teams of interdisciplinary professionals who share the same goal (related to the client's wellbeing) has been our strategy. We have seen successful outcomes with our Palliative Care collaborative work with Colorado Access, Kaiser Permanente, and New West Physicians.

We find that creating one plan of care that clarifies the outcomes to be achieved as an interdisciplinary team, and clearly defining the role of each team member is a winning approach to behavioral health integration.

Equally important, is to allow, empower and educate every client to recognize their priorities of care, and what that means for them. Develop a plan of with the client as the driver of that care.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	Currently, there isn't a payment structure in place for providers to be reimbursed for in-home social work with palliative care clients.
Community Behavioral Health Services Rule	☒	☐	Historically, BHO are structured in a building and not in community. This setting makes it sometimes challenging to respond to client needs such as transportation, mobility issues, etc.
Covered diagnoses list	☒	☐	Confidentiality of BHO medical records prohibits good interdisciplinary work
Different behavioral / physical health reimbursement	☒	☐	Only limited clinical professionals' services are reimbursed in palliative care, and when clinical professionals are working under the behavioral health scope, this falls into a separate line of service which prohibits billing.
Institutions for Mental Diseases exclusion	☒	☐	We observe too many silos in our health care system and the stigma of behavioral health care makes it even harder to break those silos.
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☒	☐	Yes, because primary care physicians can only do so much and are not reimbursed adequately to take care of everything else that needs attention. Ideally primary care would be the holder of a client's care.
Per-member per-month amount	☒	☐	Currently this is barrier because these are higher costs of care that do not account for the even higher costs of emergency room prevention. We contend that we need to come up with how to help people that are currently outside of hospital walls and health care systems.
Physical space constraints	☒	☐	Work cannot be done successful in a building. There is a segment of the populations that need us to go to them. A plan on how to reach clients where they are is most needed.

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Privacy Laws (HIPAA, 42 CFR)	☒	☐	Accessing the medical records (physical health and mental health) has been challenging for us. For interdisciplinary and collaborative work to be successful, we need records to live in the same system. We have found that our palliative care work could benefit from this type of data integration.
Professional / cultural divisions	☒	☐	In our work, we experience silos between the various health care providers. We see health care professionals trying to make it work on an individual and personal level, but the systems are not integrated.
RCCO or BHO contracts	☒	☐	We are not far enough along the continuum to know this. In rural communities BH is a difficult service to provide given that it can be so challenging to recruit qualified professionals into rural areas.
Staff capacity	☒	☐	Same as above. We do see the need for navigators or community health workers that can work with stable clients, with the goal of keeping them stable.
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☒	☐	Same as above. Ideally, records would be accessed and evaluated for reimbursement as coordinated care.
Training	☐	☐	More training. Interdisciplinary training is suggested
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

Collaboration. Care Coordination. Clinical, home and/or community based interactions. Interdisciplinary team based approach to care coordination.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Through an assessment of client and client records, determine the level of behavioral health the client may need (or maybe come up with a set of criteria): social worker, psychology, psychiatry, counseling, etc.

Evaluate how the different levels of behavioral health services contribute to outcomes and assign reimbursement based on level of intervention vs. outcomes.

Centering our care on the client and getting to know how a client is feeling about their interaction with team and the world is critical to getting it right.

Identify what is a normal response to life stressors vs. true behavioral health issues.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

The intentional coordination and integration of services (physical, behavioral, emotional) needed to achieve positive health and wellbeing outcomes for clients

b. How should RCCOs prioritize who receives care coordination first?

Evaluate where the highest needs and the highest costs in health care are and start there. Find the hard to reach clients. Our biggest challenges as a system are with the hard to reach clients; with those who we don't see in our systems.

c. How should RCCOs identify clients and families who need care coordination?

Through medical homes, family health centers, schools, nonprofit organizations and other community groups. Claims data, although delayed could be used in conjunction with predictive modeling.
Perhaps utilize Community Health Workers to identify families.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

Share all health records or ask the members directly (through a survey or focus group). Consider developing preferred network of providers to better coordinate care and reduce variation.

12) What services should be coordinated and are there services that should not be a part of care coordination?

The Denver Hospice believes that anything that would contribute to the positive outcome and wellbeing of a client should be considered part of care coordination.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

We need to know how the client feels about his/her care. We need to ask them directly. In our experience, if you ask clients and engage them in their own care management, they will share what they need. Perhaps use motivational interviewing to encourage clients to share.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

We believe some of that is already happening in the ACC.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

Being in the home or face to face is really important. And not just once in a home. We need more than a snapshot. Seeing clients in their personal environment (when appropriate) can help us empower the client and implement better coordination because we will have deeper information that does not always make its way into a medical record.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

There will be duplication. Perhaps set up a system that identifies duplication. Leave information in the home for what services the member is receiving. If client is being served at home set up a "relay" sort of system where care providers can leave information for each other.

d. What are the gaps in care coordination across the continuum of care?

e. Different environment of care delivery operating in silos. We find that transitions points between arenas of care is where clients experience great challenges (from a hospital to home, from hospital to hospice care, from counseling to hospital, etc.). We recommend taking a closer look at those transitions areas

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	**Should the RCCO have a role?** Yes	No	**Should the RCCOs coordinate with community supports and services?** Yes	**Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?**
Abuse, neglect, and trauma	☒	☐	☒	Evaluate reimbursement or payment possibilities for supports.
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	
Daycare / childcare	☒	☐	☒	
Economic stability & employment	☐	☐	☒	
Education	☐	☐	☒	

Environment	☒	☐	☒	Determine what's the best environment and make suggestions with the input of the client
Food access / nutrition	☒	☐	☒	
Health literacy	☒	☐	☒	
Housing	☒	☐	☒	
Language or translation services	☒	☐	☒	
Literacy	☐	☐	☒	Offering resources
Transportation	☒	☐	☒	Depending on what exactly are the client's transportation needs; if it's to get to primary care doctor, then RCCOs should find a way to integrate this critical service.
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	**Coordinate care?** Yes	No	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☒	☐	They could be providing coordination of care with physicians, primary and specialty physicians.
Certified Addiction Councilors	☒	☐	As appropriate
Certified Nurse Midwives	☒	☐	As appropriate
Community Health Workers	☒	☐	This would be a good resource when clients are stable. CHW could be responsible for making sure stay healthy.
Generalists (BA/BS/MA/MS)	☐	☐	Don't know
Health Coaches	☒	☐	As appropriate
Licensed Clinical Social Workers	☒	☐	We think MSW can also be valuable. Not everyone needs to be a clinical licensed social worker. More of the holistic social work emphasis is also needed and could be beneficial to certain clients. Insisting on a Licensed Clinical

			Social Worker excludes the new grad from entering this work force realm.
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☒	☐	Frequently BH is the driver for interfering with the desired outcome; could consider this professional or physician as hub of coordination.
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☒	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	More holistic approach to health is appropriate for some clients
Nurse Practitioners	☒	☐	
Client Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☒	☐	
Psychiatrists	☒	☐	
Psychologists	☒	☐	
Registered Nurses	☒	☐	
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, **or** if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☐	Because the needs of the mother will also need to be taking into consideration
Children	☒	☐	Children's specialty and knowledge
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☒	☐	
Children with a chronic illness	☐	☐	

Children with a serious emotional disturbance	☒	☒	Such as grief emotional support
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☒	
Pregnant women	☐	☐	
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☒	☐	High risk/high costs
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	High risk/high costs
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☒	☐	High risk/high costs
Frail elderly clients	☒	☐	
Clients in palliative care	☒	☒	A combination of general and specialized cared coordination would be best
Other populations please comment: need more credential individuals in these areas. Support for these environments.			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

It is our hope that long term palliative care and hospice care for children is included in the RCCOs consideration, and that the Denver Hospice can be a partner in this very important work for children.

19) How should care coordination be evaluated? How should its outcomes be measured?

We believe that evaluation based on population health, cost reduction and client experience are appropriate factors to measure and evaluate.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

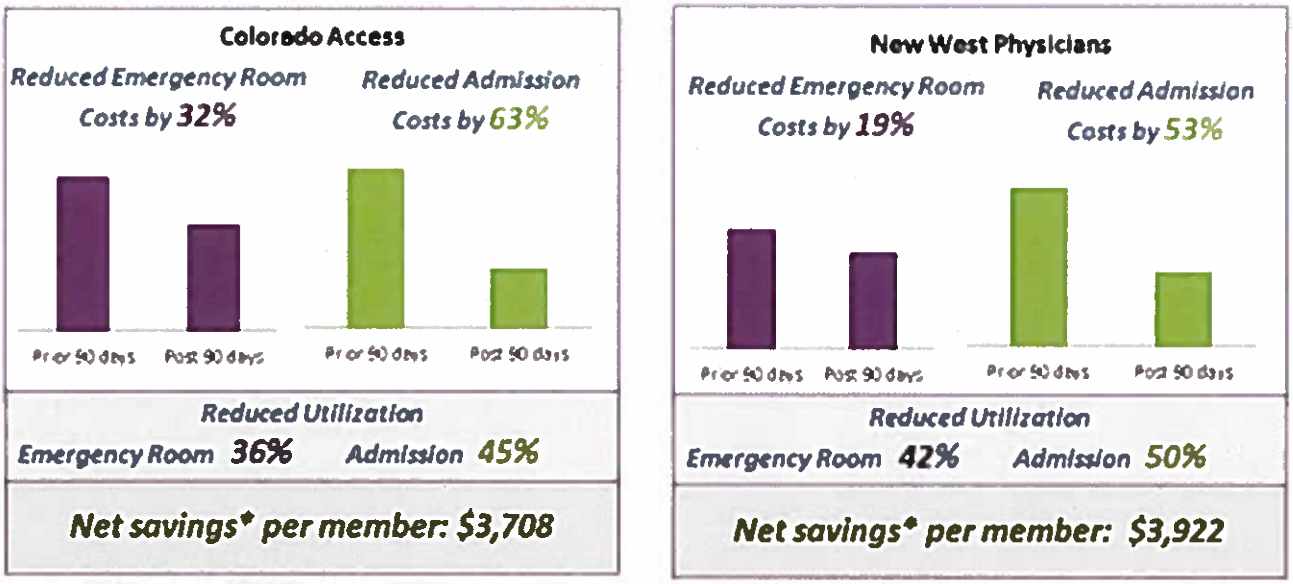
a. What is the PMPM cost for providing care coordination services?

For the Denver Hospice, the cost of providing palliative care in the home setting and telephonic support is approximately $1200 month. This includes very intentional and robust care management, for a defined 90 day

episode. We believe that when our services were evaluated for cost avoidance the value was clear. Our interdisciplinary in-home team for palliative care is a cost savings approach. See pilot evaluation and data below:

Optio Care Support for Advanced Illness Management
Partnering to provide community-based palliative care –outcomes & ROI

Triple AIM: Better Health, Better Care, Lower Costs
Proven results when partner in care delivery



* Net savings after program cost

THE DENVER HOSPICE

optio HEALTH SERVICES

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

Yes, we agree that having the PMPM vary by populations may be a good strategy; to consider 3-tiers, by chronic disease and levels of care coordination.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

Acuity may be the best approach but proactively identifying may be challenging; population is best approach at present.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

May vary with a tiered approach to care coordination, active case requirements.

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

Cost avoidance/savings is most important.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Reduce variation by contracting a preferred network of providers for community-based services.
Data reporting must also be standardized, focus on Triple AIM outcomes.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Years of experience in community work. Familiarity and understanding of population needs. Partnership history and capabilities. Outcomes attributed to a Triple AIM focus.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

Aligning the PCMP and RCCO makes intuitive sense: better coordination, better understanding of each other's work, leading to improved outcomes.

27) Should the RCCO region maps change? Why or why not? If so, how?

NA

28) Should the BHO region maps change? Why or why not? If so, how?

NA

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

NA

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

Rules regarding what services receive and level of reimbursement.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

Benefit structure is not wide enough. It does not cover palliative care.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

It depends on the level of coordination the identified population requires.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

Yes, we would very much like to become a Medicaid provider. A reimbursement model for our work would be necessary.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

N/A

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

N/A

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

N/A

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

N/A

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

N/A

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

Centering on the client, asking the client, strategies based on what clients need. Making sure the transition between health arenas is seamless and coordinated.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

Regular engagement via various methods: in person, online, regular key informant interviews/focus groups, hotline. Ideally if clients would have one center/medical home that was the gatekeeper, engagement would occur through that medical home.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

With a continuous dialogue with community, and particularly with clients and those receiving services.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Online, Offline, and in person

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

Currently we believe there are populations being left out because there are necessary yet non-reimbursed services.

a. If no, what are the gaps?

Palliative care for those who need it is currently a gap in the system because it's not reimbursable.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

N/A

b. What role should pharmacies play in the next iteration of the ACC Program?

N/A

c. What role should specialists play in the next iteration of the ACC Program?

Palliative and Hospice care should be part of what is offered.

d. What role should home health play in the next iteration of the ACC Program?

Home health programs should play a larger role. Not as long term care, but could be a bridge to integrate behavioral and physical health as seen in outcomes by The Denver Hospice palliative care programs

e. What role should hospice care play in the next iteration of the ACC Program?

A larger role. Palliative and Hospice care are vital to improving quality and reducing costs.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

N/A

g. What role should counties play in the next iteration of the ACC Program?

N/A

h. What role should local public health agencies play in the next iteration of the ACC Program?

N/A

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

Yes, we believe that seeking partnerships with community organizations will help the system provide a more holistic and comprehensive service

45) How can RCCOs help to support clients and families in making and keeping appointments?

With reminders and facilitate solutions for other factors that get in the way (transportation, language, literacy, engagement, etc.)

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Client Navigators as part of the next RFP?

Yes! But let's think of how to reimburse. They could be the bridge for the continuum of care. They could keep clients engaged and help them transition from one system to another.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☒
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☒

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

Oral health is as important as nutrition. We believe RCCOs should find ways to integrate these very important components.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

Solidify relationships between clients and providers, clients and systems. This work is about relationships.

b. What RCCO requirements would ensure cultural competency?

Each provider should really address this. Maybe RCCOs can offer guidelines.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

There is quite a bit of competence that is needed to be able to provide adequate cultural and linguistically services. This is also a continuous process of learning and improving in this area.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Inequalities are likely to be there, but they can be reduced by training our providers and by integrating workers who are from community into our systems.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

To be considered.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Look to pilots and programs that have demonstrated cost savings in these areas, like palliative care.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others	Recommend areas of focus are limited to those that impact desired outcomes, e.g., those supporting Triple AIM.			

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

N/A

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

Dependent upon role/scope of PCMP.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

Good for population health.

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

Give incentives to those who are achieving cost savings. Then re-invest.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

N/A as we are not a PCMP; however, interested in risk-sharing opportunities.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Not at this time. Define a risk-share model tied to outcomes and cost savings. Current fee for service model is prohibitive/does not align with desired outcomes.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

N/A

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

None.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

Define the basic service expectations. Research the cost savings potential. Be cautious and flexible. Be nimble with expectation to allow for change.

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/client experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	This is a good tool
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☒	☐	Internal survey with your own clients. Survey, and call people. Interview partners.
Client Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here. Use external auditing; agree upon a standard tool that is accepted/used by other community activities.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

Define cost avoidance instead of claims? (it's an idea)

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

In simple, easy to digest ways. Again, align to Triple AIM to be able to adapt as data collection and reporting matures.

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

Less measures and they should be weighted, cost avoidance being the most important.

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

May consider a weighted system when thinking in terms of KPIs as populations vary.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Integrate both of these measures.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

As above; begin with what is available, then can supplement/adapt payment model as progresses.

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

N/A

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Palliative care currently poorly/not reimbursed.
Data tracking includes:

- Client experience / HCHAPS
- Cost savings/cost avoidance
- Advanced Care planning metrics

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☒	☒
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☐	☒
Smartphone app	☐	☒
Other: Privacy HIPPA and infrastructure play a role.		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Client education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other: We look at what partners need, and invest in what would make the partnership stronger	☐	☐

Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-S, where 1 are those items least-likely to be used, and S are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☐
Care management tool	☐	☐	☐	☐	☐
Care transitions alerts	☐	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☐
Client education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☐
Other: These are generally, all important and could be useful if they do not become a barrier to care.	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Compatibility of systems seems to be a challenge in our work. Even the ones that have good health systems do not work well with home hospice work.

81) How can Health Information Technology support Behavioral Health Integration?

The information itself or part of it could be accessible to other disciplines that need it.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

N/A

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

N/A

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

N/A

86) How can the RCCOs support providers' access to actionable and timely clinical data?

Electronic portal

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

Simple, easily understood, customer friendly.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

N/A

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

N/A

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 068

Accepted by: KJDW

Notes: Standard cover sheet added; converted to Word

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Paul Belli
Location: Aurora, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Shield HealthCare
Location: Aurora, CO
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): **Shield Healthcare is a major home medical supply and "safety net" provider in Colorado and wanted to comment on the questions that pertain to us, an Ancillary Provider. Our company provides home medical supplies including Incontinent, Enteral, Urology, Wound and Ostomy products to Medicare, Medicaid, Medicaid managed care and insurance members at home and bills their insurance.**

Are you currently involved in the ACC program?

☐ Yes
☐ No
☐ I don't know

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Click here to enter text.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

P22, 43)

QUESTION

Does the current network of PCMP, specialists, behavioral health providers, hospitals, pharmacies, dental, home health and non-medical providers adequately serve the ACC population?

RESPONSE

The Network for mail order home medical providers is adequate to cover the State. DME/RT providers are adequate on the Front Range, but with the implementation of Medicare's Competitive Bid program, DME/Enteral providers are more scarce. The Rural and mountain regions of Colorado are a challenge to find adequate coverage of DME and Respiratory providers.

P24, 50)

QUESTION

Should the next RFP allow for preferred networks for specialty, facility or ancillary care?

RESPONSE:

(Ancillary Providers) All DME, RT and home medical suppliers should be allowed to serve Medicaid customers upon a referral. A hospital, physicians group, network, could have preferred providers, IF there is objective criteria that all providers can compete for that "preferred" designation.

P27 60)

QUESTION

IF PCMPs could voluntary elect to receive capitation payments, rather than fee for service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

RESPONSE

IF you provide Capitated payments to physicians, hospitals or networks, the payments should NOT include DME, RT or supplies. DME, RT and supplies should remain under the Medicaid Fee For Service. Most physician groups and networks do not clearly understand the Medicaid qualification rules and quantities for DME, RT and supplies and generally respond with excessive administrative requirements that do not enhance patient care.

P30, 76)

QUESTION

For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

RESPONSE

Shield is not being reimbursed for quality measures that it currently achieves in providing home medical supplies. Quality measures might include: Patient satisfaction ratings, timely delivery, quality products, phone answer response time, back order frequency, etc.

P33, 85)

QUESTION

Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful?

RESPONSE

A Medicaid provider directory should include:

- Organized by Regions covered: Denver Metro Area | Foothills | Palmer Divide | Urban Corridor | Eastern Plains | Front Range | Mountains | Western Slope | Continental Divide

- Products/Services/specialty provided
- Phone, fax and email contact information

P33 86)

QUESTION

How can the RCCO support provider's access actionable and timely clinical data?

RESPONSE

Create an electronic Medical Records file that member providers can access with a HIPAA compliant firewall and log in.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 069

Accepted by: KJDW

Notes: Standard cover sheet added; converted from PDF

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Steven Poole

Location: Aurora, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Children's Healthcare Access Program (CCHAP)

Location: All of Colorado

☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☒ Client advocate
☒ Medical provider / PCMP / other provider
   i. Type or specialty: Pediatrics covered by Medicaid.
   ii. Area of practice: Click here to enter text.
☒ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): **Advocate for children on Medicaid**

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Clinician and advocate.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

I am a pediatrician whose clinic is mostly children I also am on the Executive Committee of the Colorado Chapter of the American Academy of Pediatircs
I am also part of the CCHAP team.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)

Are you currently involved in the ACC program?

☒ Yes

☐ No

☐ I don't know

you answered "yes" above, how long?

☐ Less than one year

☐ 1-2 years

☐ 2-3 years

☐ 3-4 years

☒ Since before the program was implemented.

☐ Unlikely without significant changes

☐ Will not seek to participate

☒ N/A

CCHAP will continue to be involved with the ACC and RCCO's to assist with communication, training, and If

advocate for policies and procedures that address the needs of children.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.

- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it. o So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
    - Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family and often involves different community resources than for adults

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family. This is probably the most important issue to solve. It drives measurement of outcomes, it drives the focus of the medical home to improve care, it is central to affordability of practice transformation and meeting the KPIs, and it is key to patient experience.

- Practices report to CCHAP that the attribution process is difficult to understand, use and correct. Many pediatric practices still have adults on their list unknown to them, and they do not seem to be able to remove them. Sending lists and creating spread sheets are tedious and time consuming. Practices do not

have this time or expertise. Attribution needs to be fixed to create a simple way to add and remove members.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to have an impact on the Medicaid recipient's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Both family practices and pediatric practices report that the SDAC does not accurately reflect the data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on well child visits and health care screening. The RFP should ask how RCCOs and HCPF will improve the accuracy of its SDAC data and how they will take advantage of the more accurate practice-based data.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. So, the RFP should ask how RCCOs intend to deal with this

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

But of course the medical home will need a portion of the RCCO's pmpm in order to afford to provide that level of care coordination.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We have heard many practices say that they are grateful that CCHAP keeps them informed..

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

- **The CPACK program** developed by CBHC is a very good program, particularly the following:
  - Assistance with finding a behavioral health provider for patients
  - Telephone consultation by a child psychiatrist
    The training component was not as helpful. We recommend that BHOs be required to provide the 2 components above as part of their new contracts

- **Ongoing development of the Independent Provider Networks.** This provides patients and families with more options in terms of selecting a behavioral health provider outside of the CMHC. This may also provide opportunities for families to gain opportunities to see behavioral health specialists in the their local communities.

- **Commitment to integrated care.** At the local level, there are many community mental health centers that are providing co-location of behavioral health providers within primary care settings. This is a step in the right direction; though the work cannot end there. In terms of standard of care, billing issues, and paperwork demands, this cannot be the only behavioral health integration effort at the BHO level. Ideally, community practices and clinics would be able to have the option of employing a behavioral health provider to be devoted entirely to the needs of their population. However, currently there are several barriers that make true integration nearly impossible.

4) What is not working well in the BHO system?

- BHOs say they are limited by policies to not be able to provide services for children who have symptoms or abnormal behaviors but no billable diagnosis.

- Children with specialized behavioral health needs, such as children with autism or dually-diagnosed children (those with developmental disabilities and socio-emotional or behavioral disorders) have little or no access to needed services. Or these services are sparse and extremely difficult to access.

- Value Options leadership is made up of the heads of mental health centers, which is a conflict of interest. The BHO function should be moved to the RCCOs and BHOs should be integrated into the RCCOs

- They are involved in separate regions. Regions should be identical to ensure collaboration and improved practices between the efforts for both organizations.

- **Difficulties with credentialing.** This process changes from BHO-to-BHO, is long and tedious, and in some cases, requires behavioral health providers to have worked with Medicaid populations for at least 5 years (?). This alienates a substantial portion of an already too-small workforce. Licensed behavioral health providers already engage in a lengthy process through DORA, in which their credentials and past work experiences are examined and verified. This process should have some consistency amongst BHOs and should be coordinated with other state departments with similar functions.

- **Referral processes.** Care coordination for behavioral health should occur at the practice level. Creating an additional step (by having providers fax referral forms to the BHO) creates an additional barrier for patients/families and practices. When referrals are made, direct contact should be with the local CMHC from the practice.

- **No streamlined processes across BHOs and RCCOs.** Primary care practices have patients and families from multiple counties in their practice at any given time. Having separate policies and procedures for each BHO and RCCO makes it difficult for providers to know how to get assistance when needed. Having one procedure, one contact person, and one phone number would allow BHOs/RCCOs to be more effectively utilized by practices.

- **Access to child psychiatrists.** There is an extreme (and known) shortage of psychiatrists statewide; this becomes increasingly dire when discussing access to child psychiatrists. The CPACK program is currently filling a critical void; but is a grant-funded program in danger of losing funding. BHOs could potentially have a role in helping to provide this much needed access.

- It is difficult to obtain coverage to treat behavioral problems in people with autism.

5) What is working well with RCCO and BHO collaboration right now?

- Colorado Access RCCO and BHO for RCCO region 5 works better because at least they are housed together and sometimes communicate. This is an example of a good start toward integration of BHOs and RCCOs. However, even CO Access and Access Behavioral Care need to work harder on communicating and coordinating.

6) What is not working well with RCCO and BHO collaboration right now?

- **Little to no communication or coordination between RCCOs and BHOs.** Operating as two completely independent systems. Both systems have their own processes for care coordination, for referrals, and don't seem to communicate as much as is needed. For integrated care to be successful at the practice level, it has to be operating successfully at a systems level. This is one of the biggest issues for integration for the Medicaid population.

- **Duplication of services.** If there was increased communication and alignment between the RCCOs and the BHOs, service duplication could be minimized, there would be cost savings, and it would be easier for patients and families to access services. For example, both BHOs and RCCOs offer care coordination services. In some cases, the local mental health center has also been delegated to provide care coordination. At the practice and provider level, it's often difficult to know which system to access to address a family's needs, particularly if a child has both behavioral health and physical health needs. Resources could be conserved and systems could be more effective if there was one access point for care coordination.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing 5DAC data

is just one way to understand the activities within a medical home. SDAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients
  b. Telephone consultation by a child psychiatrist to primary care providers
  We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

- **Payment reform.** Though this is a long-term goal, there are things in the short-term that will promote the financial sustainability of integrated care. Open the behavioral health and wellness CPT codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration. Also, in the current BHO rule, there is a covered diagnoses list that is required to bill. This list does not allow a provider to bill for v codes (physical or sexual abuse of a child, neglect of a child, parent-child relational problem, etc.) or other psychosocial or family stressors that are known precursors to mental illness; this is the opposite of a preventative approach and encourages pediatric BH providers to find a diagnosis – when the behavioral presentation is really due to family circumstances. Additionally, one of the goals in recent years for Colorado has been to decrease the number of children taking psychotropic medications. Allowing providers to intervene earlier would have a direct positive impact on that goal. The recommendation would be to allow for the billing of v codes (from DSM-5) and related psychosocial conditions (as opposed to being diagnosis driven).

- **Financial support of true integration, as opposed to co-location.** This would be another reason that BHOs and RCCOs need to be fully aligned in their payment systems and in other areas – as long as the payment remains siloed, the services will remain siloed. Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

- **Establish a standard of care for integrated BH providers and make the rules/regulations/guidelines accessible and clear.** This also includes credentialing requirements and providing immediate training on the correct use of HIPAA regulations. Any committee or group that is tasked with creating the standard of care of integrated behavioral health providers working in primary care settings should be composed of local clinicians and experts in the area (as opposed to strictly policymakers). This group should also provide guidance on the paperwork and credentialing requirements. All agencies involved in licensing and credentialing for behavioral health professionals (e.g., DORA, OBH) should be present.

- **Provide infrastructure and funding for data collection and management.** Utilizing SDAC data is just one way to understand the activities within a medical home – others are needed. There are currently projects being developed in the state that would utilize other modalities (e.g., IPad technology) to help practices collect data efficiently and effectively at the practice level. There will need to be an investment in the development of these programs and many practices would need financial assistance with implementation. However, this would be a way for practices to track all the activities that the state would like monitor (e.g., screening rates, follow-up, referral) and would allow the practice to improve patient and family care.

- **Support of care coordination activities.** Much of the care coordination will have to be done within the medical home. HCPF needs to be willing to help the integrated behavioral health provider understand how to be reimbursed for the care coordination that they will need to do on behalf of the Medicaid patient.

- **CMHC Policy and procedure change (via the BHO contract).** It is important to recognize the ways in which current policy can be problematic for practices, patients, and families. Currently, the BHO contract requires CMHC's to offer "intakes" or evaluations to patients/families within 7 days of referral from a primary care practice. This sounds reasonable. In theory, there are several complications: 1.) Offering a slot for an intake does not qualify as providing a gold standard of care. It has been frequently reported that time slots offered for intake appointments are typically during the 8-4 workday – this makes a family or patient choose between work and their health (and families are already much less likely to show up for behavioral health appointments). There needs to be increased flexibility in this area. 2.) Also, offering an intake is not the same as providing therapy. Patients or families may come in for intakes and typically wait to be assigned a therapist. Then wait for that assigned therapist to call and schedule an appointment. This could be weeks after an initial referral. This process does not translate to patient- or family- centered care. This is just one example.

- **Sustainability and prevention.** The clear fact remains that if prevention does not become the focus of healthcare (physical and behavioral) costs will continue to skyrocket and our population will continue to develop multiple costly, chronic diseases. Prevention is the key to long-term population health and begins in infancy. So much of the behavioral health work and overall healthcare focus in Colorado has been focused on those that have already developed chronic conditions; ultimately, this does not serve our population well in the long-term. Population health is a focus of the SIM work and thus, funding and attention must be given to early childhood behavioral health, prevention, and early intervention.

- **Support of current programming and infrastructure, as opposed to creating new duplicate programs.** Colorado is an innovative state in many ways and has already begun this work through the efforts of multiple programs, statewide initiatives, and community organizations. Programs like the CPACK program developed by CBHC address statewide disparities in the availability of child psychiatrists and promote behavioral health integration in primary care. Effort should be channeled into supporting existing effective programming, not creating new infrastructure.

8) Barriers to the integration of behavioral health and physical health services. Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	Barrier? No	If yes, please provide details of the barrier and how to address it:
	☒	☐	The current financial system for CMHC's only supports one form of integration – the colocation of a behavioral health provider that is based at the CMHC. Since funding for CMHC's is strictly determined by the number of "members" served, CMHC's are not currently incentivized to support an integrated behavioral health provider working in a primary care office (that is outside of their system). This can create a feeling of competition between CMHC providers and other integrated BH providers. Yet, in order for our behavioral health system to be successful, we need all providers to coordinate care and work together. There is no simple solution to this – this requires both culture change and payment reform. CMHC's should be provided funding based on community need; many rural or frontier parts of the state are less populated, yet have poorer behavioral health outcomes and need more programs/services. Additionally, CMHC's have practiced in a manner that may discourage coordination with PCP's – demanding multiple releases of information (before even getting on the phone with a PCP – which is NOT mandated by federal HIPAA guidelines) and failing to close the loop once a family has been referred. There needs to be immediate training statewide about the TRUE implications of HIPAA in all the CMHCs; instead of continuing to let it be a barrier to communication between providers. Additionally, each CMHC needs to have a designated person to handle communication and relationships between the CMHC and primary care practices. There needs to be ONE contact person (ideally there would be multiple, depending on the number of practices in the region) and one phone number to call and follow-up on referrals.
	☒	☐	If Colorado is serious about integrated care and allowing behavioral health professionals to successfully work alongside physical health providers, the state cannot just apply current behavioral health services rule to integrated care settings. There need to be guidelines for standard of care (for BH providers in integrated care settings) but paperwork requirements, requirements for updating "treatment plans" (which may or may not be relevant in integrated settings), need to reflect the work done by an

Community Mental Health Center financing structure[1]

Community Behavioral Health Services Rule

[1] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Covered diagnoses list			patients or families a day (in a true integrated model) and so, requiring lengthy intake forms, treatment plans, and other cumbersome paperwork is not required for providing quality care and will add nothing to a patient/family experience. The requirements for integrated BH providers need to be consistent with those required of physical health providers – allowing BHP's to spend more time providing quality clinical care and training (as opposed to doing paperwork).
Different behavioral / physical health reimbursement	☒	☐	Many children do not have a covered diagnosis but need treatment For the pediatric population, the focus must be prevention and addressing psychosocial, economic, and family stressors BEFORE they develop into full-fledge psychiatric disorders. Investing in prevention among children (particularly those on Medicaid) is the only way to decrease the development of chronic disease in the adult population (which is one of the largest drivers of skyrocketing healthcare costs). The recommendation would be to allow for the billing of v codes (from D5M-5) and related psychosocial conditions (as opposed to being diagnosis driven).
Institutions for Mental Diseases exclusion OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	Need behavioral health codes open for medical homes. Solve the problem as to whose patient is this and who is the primary care provider. With $3PMPM every one wants to be the primary. For the pediatric population, the focus must be prevention and addressing psychosocial, economic, and family stressors BEFORE they develop into full-fledge psychiatric disorders. Investing in prevention among children (particularly those on Medicaid) is the only way to decrease the development of chronic disease in the adult population (which is one of the largest drivers of skyrocketing healthcare costs). The recommendation would be to allow for the billing of v codes (from D5M-5) and related psychosocial conditions (as opposed to being diagnosis driven).
	☐	☐	
	☒	☐	Solve the release of information problem between the two different systems so the patient's needs and health are primary not the systems. All done with the patient as the focus. Currently, it's difficult to understand if OBH has any regulatory responsibility to behavioral health providers working within primary care. OBH has traditionally governed 27-65 designated facilities, which (in many cases) does not include primary care settings. This is

			establishment of treatment plans, crisis procedures, HIPAA regulation, etc. for individuals providing behavioral health and substance abuse services. There needs to be a training (by OBH or another identified agency) that clarifies the rules/guidelines for integrated behavioral health providers working within primary care settings. This should be 100% consistent with the requirements for physical health providers; there should not be more paperwork or reporting demands.
PCMP financing structure	☒	☐	
Per-member per-month amount	☒	☐	One of the core components of allowing behavioral health integration to be successful is care coordination. There need to be increased reimbursement levels to allow for care coordination to be completed within the medical home.
Physical space constraints	☒	☐	Always
Privacy Laws (HIPAA, 42 CFR)	☒	☐	Attorneys tend to give very conservative opinions that are not consistent with HIPPA rules. We need clinicians to describe the documentation methods they This issue needs to be addressed through training – immediately and statewide. Federal HIPPA states that providers can communicate with one another if in the best interest of patient (without a release of information). The only stricter state statute in Colorado (42 CFR) applies only to substance abuse and requires additional permissions. There is nothing stopping behavioral health providers and PCMPs from communicating from a HIPPA perspective (aside from in the case of substance abuse). Needing this many permissions and releases is a myth (primarily perpetuated by behavioral health). Dayna Matthew is a law professor at the University of Colorado Law School who is an expert in this area and also knows the local laws/statutes. She should be consulted and should assist in getting all trainings and discussions to occur.
	☒	☐	RCCOs and BHOs need to be merged, paid in similar manners, have aligned incentives, together all trainings and discussions to occur statewide. ~~remain siloed, it is difficult for the community practices and clinics to function in an integrated manner.~~ We can provide coaching on how to effectively work together, I think PCMPs and integrated behavioral health providers will be fine working together.
	☐	☒	Though there are practices that have been doing integrated behavioral health for decades, many PCP's and behavioral health providers are unfamiliar with the practice of integrated care. Most have a theoretical understanding of integrated care, but putting it into practice With a little coaching on how to effectively work together, PCMPs and integrated behavioral health providers are able to be successful serving patients and
	☐	☒	The Tri-agency Task Force, composed of individuals from multiple state agencies (CDPHE, HCPF, OBH, HHS) and community stakeholders, identified a whole host of policies that are barriers. A detailed report on how to fix those barriers was provided to leadership at HHS. This would be a great place to start.
	☒	☐	

Professional / cultural divisions RCCO or BHO contracts Staff capacity State/Federal rules or reporting requirements	☐	☒	This can be worked out. Utilizing SDAC data is just one way to understand the activities within a medical home – others are needed. There are currently projects being developed in the state that would utilize other modalities (e.g., IPad technology) to help practices collect data efficiently and effectively at the practice level. There will need to be an investment in the development of these programs and many practices would need financial assistance with implementation. However, this would be a way for practices to track all the activities that the state would like monitor (e.g., screening rates, follow-up, referral) and would allow the practice to improve patient and family care.
Technical resources / data sharing	☒	☐	Integrated behavioral health providers (IBHPs) for children require a very different skill set than IBHPs for adults. The Department of Child Psychiatry at UCDenver and Children's Hospital, along with CCHAP are expanding their training capacities. There is also work being done to develop a training program uniquely geared towards pediatric IBHPs – this is vital to providing effective and high quality care.
Please type your response here.			

Training

Others

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

The American Academy of Child and Adolescent Psychiatrists (AACAP) has identified several components that are vital to providing high quality behavioral health within a pediatric medical home:

- Prevention and screening
- Early Intervention
- Routine assessment and treatment
- Specialty consultation
- Specialized Treatment
- Coordination of services and monitoring

Adapted from the "Best Principles for Integration of Child Psychiatry into the Pediatric Health Home" 2012

This framework is based on key general principles that are aligned with the goals and objectives of multiple professional associations that currently support integrated behavioral health efforts. These principles include family-focused care, professional collaboration, care plan development, and care coordination.

The integrated behavioral health provider (IBHP) in a medical home that serves children on Medicaid should have the following skills:

- A command of child development to guide screening and referral decisions
- Ability to manage many aspects of post-partun depression
- Ability to manage common minor behavior problems in children
- Ability to provide early childhood intervention
- Ability to handle common behavioral issues in school age children, including counseling around ADHD
- Ability to assess and manage or refer adolescent behavioral health issues
- Ability to assess, manage or refer substance abuse issues in children or teens
- Skills in addressing socioeconomic barriers for the whole family
- Ability to oversee care coordination for behavioral health issues for the whole family

10) Please share any other general advice or suggestions you may have about behavioral health integration.

- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients
  b. Telephone consultation by a child psychiatrist

The training component was not as helpful. We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- There needs to be better reimbursement for behavioral health care in the medical home setting.

- Colorado Medicaid needs to open behavioral health codes (96150 – 96155).

- The BHOs should be integrated with the RCCOs, have the same regions, reduce duplication of efforts and have better alignment of incentives and payment that support integrated care.

- There are many policies that are barriers to integration.

How will the RCCOs support the needed work force development? To integrate you need the expertise with in the practice for identifying need and the folks trained and integrated to meet the need. How are we going to train/help the staff get to the point to support a family and to help them to understand the need they have for services? This issue should be a focus of the next RFP how to train and pay for these services in a sustainable manner.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination? Care Coordination is an organized/structured set of activities to support a patient receiving the appropriate services and resources necessary to achieve the best results necessary. These services are provided in a patient/family centered way which includes assessment of needs and strengths, a developed care plan and goals focused on the family and follow up on activities in the plan to be sure that needs were met or support services provided so that services stay focused on the needs identified by family.

b. How should RCCOs prioritize who receives care coordination first? High on the list need to be referrals from provider and practice staff, patients/families needing high levels of specialty care, premature infants, long term care services and palliative care, children and families needing waivers and children not showing up for their appointments. A request from the patient/family for help should also be considered a high priority.

c. How should RCCOs identify clients and families who need care coordination? We believe the effort and staff hours should go to those patients/families where change can be made such as socioeconomic issues, no show issues, lack of transportation. They should also help with navigating the health care system. Very high utilizers of emergency departments are easily identified as needing care coordination.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider? Monthly activity reports.

12) What services should be coordinated and are there services that should not be a part of care coordination?

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes by assisting families to find resoruces for needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

Need is determined by the patient and family. Care Coordination is basically built on a relationship and that relationship must be developed in a trust-filled, patient-centered, supportive environment.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today? The care coordinators themselves (and the medical home) are not aware of whom else is involved.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different? Takes place in school, non-profit organization, religious organizations, between friends and in families to name a few. These informal and formal relationships need to be supported, coordinated and nurtured. We are looking for results that lead to better lives, not credit for who did something.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships? Allow providers to help patients and families and intervene to support

the work closest to the patient and in the patient/families community. RCCO centric care coordination is distant for the patient/family and not in tune with the system that the patient/family currently functions.

d. What are the gaps in care coordination across the continuum of care? There is a lack of understanding particular systems and a lack of relationship in the nondelegated system being created. It has lost its personal touch in most instances. In
the pediatric system, there are gaps in hospital to community, particular for preemie babies, interaction with schools and day care, developmental screening and treatment, transportation support, health literacy, and transition to adulthood. All vital for the successful growth of children.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	**Should the RCCO have a role?** Yes	No	**Should the RCCOs coordinate with community supports and services?** Yes	**Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?**

Abuse, neglect, and trauma	☒	☐	☐	Reporting abuse and neglect, both child and elder and supporting the investigating agencies and helping with needed services not being provided by another agency.
Affordability (assistance with prescriptions or co-pays)	☒	☐	☐	Don't assist everyone, but have resources so that needed help can be obtained and the provider's identified services can be received. Help families find resources and document that the family was actually helped.
Daycare / childcare	☒	☐	☐	Help families find resources and document that the family was actually helped.
Economic stability & employment	☒	☐	☐	Help families find resources and document that the family was actually helped.
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☒	☐	☐	Help families find resources and document that the family was actually helped.
Health literacy	☒	☐	☐	Help families find resources and document that the family was actually helped. Have RCCOs take responsibility for finding good training for providers and staff on this topic.
Housing	☒	☐	☐	Help families find resources and document

				that the family was actually helped.
Language or translation services	☒	☐	☐	Help families find resources and document that the family was actually helped. RCCOs should support practices with easy and inexpensive ways to obtain immediate interpretation and translation of documents.
Literacy	☒	☐	☐	Help families find resources and document that the family was actually helped.
Transportation	☒	☐	☐	Help families find resources and document that the family was actually helped. Make sure that resources are available in all areas of the RCCO.
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) Requirements about who should be doing care coordination. Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

- **In answering the following question, we are assuming that care coordination is being done in the medical home**

Type:	Coordinate care?	In what capacity should these individuals coordinate care in the ACC Program?	Yes	No

Advanced Practice (Registered) Nurses	☐	☒	
Certified Addiction Councilors	☐	☒	
Certified Nurse Midwives	☒	☐	In OB Gyn office only
Community Health Workers	☒	☐	For most Medicaid recipients. Practical feet on the ground; health literacy helpers; follow up; know neighborhood and community resources
Generalists (BA/BS/MA/MS)	☒	☐	For most Medicaid recipients. Best choice; know alittle about a lot, good problem solvers
Health Coaches	☐	☐	
Licensed Clinical Social	☒	☐	For highly complex social situations or complicated mental health clients. Possibly for supervision; can also do

Workers			behavioral health, grief/loss and palliative care.
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☒	☐	For complicated mental health clients. Need to be generalist good at all ages
Licensed Professional Counselor	☒	☐	For complicated mental health clients. See above
Masters of Public Health	☐	☒	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☒	
Nurse Practitioners	☐	☒	
Patient Navigators	☒	☐	For most Medicaid recipients. Can provide very practical information to patients, help with health literacy, know area
Peer Advocates	☒	☐	For most Medicaid recipients. Can help with practical information on community; can make calls and set up appointments
Promotoras	☒	☐	For most Medicaid recipients
Psychiatrists	☐	☒	
Psychologists	☒	☐	For complicated mental health clients
Registered Nurses	☒	☐	For medically complicated complex clients. Doing this work now
Social Workers	☒	☐	For clients with very complicated social issues
Wraparound facilitators	☐	☐	We don't know what these are, but might be like Peer Advocates.
Other	Please type your response here.		

17) Care coordination requirements for specific populations. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe

Newborns and infants	☒	☐	Preemies, born with equipment needs, O2, genetic abnormalities
Children	☒	☐	Need special training regarding care coordination for children (which CCHAP can provide). Genetic abnormalities, need equipment, blind, hearing loss, developmental delays, foster care.
Children who are healthy, but in socially-complex environments	☒	☐	Need special training regarding care coordination for children (which CCHAP can provide). Legal, parental and behavioral issues as well as all the developmental issues of children and teens need special care and knowledge.
Children involved in the foster care system	☒	☐	Need special training regarding care coordination for children (which CCHAP can provide). Legal, parental and behavioral issues as well as ll the developmental issues of children and ttens need special car e and knowledge.
Children with a chronic illness	☒	☐	Special knowledge of complex medical conditions, waivers, equipment, respite is necessary.
Children with a serious emotional disturbance	☒	☐	Need special training regarding care coordination for children (which CCHAP can provide). Considered complex care need to understand needs of child and family.
Children with medical complexity	☒	☐	Need special training regarding care coordination for children (which CCHAP can provide. Needs to be a nurse providing the care coordination

Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	Need special training regarding care coordination for children (which CCHAP can provide). See above in emotional disturbance.
Transition-age adolescents	☒	☐	Persuading adult providers is hard.
Parents and families	☒	☐	Need to understand family dynamics
Pregnant women	☒	☐	Complicated medical situation
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

Working in a collaborative mode with anyone connected with the patient. RCCO staff will need to learn about the legal and temporary nature of foster care and residential care and support schools; behavioral health and physicians in helping the child receiving care to have a good care plan and make sure that plan follows the patient

19) How should care coordination be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk. There should be the development of process and clinical outcomes the show that care is happening. The measurements should be the same for RCCOs and for medical homes that have been delegated to do care coordiantionby the RCCO.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services? We believe there should be a basic payment for care coordination. This would cover the cost for monitoring, data support, and "being ready for anything. Cost $5-6 PMPM at the medical home level, which is where care coordination should be done.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population? Yes. Complex medical and social situations need more time, possibly travel and much more clinical knowledge to ensure positive outcomes. Cost $6+ PMPM for high CRG patients and families.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population? YES

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☒

101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

Measurement will have to start with process outcomes, but as folks become more proficient outcomes could be decreased no shows, patient satisfaction, use of community resources, care plans completed, increase immunization rates, proportion of patients receiving well cild visits.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

- Care coordination is best done in the medical home by members of the medical home team.
- Care coordination done from a call center in the RCCO tends to be superficial, only partially meet the needs of the patient and family, is fragmented (often fails to close the loop, i.e. follow through to be sure problems were satisfactorily met). The next best solution is for care coordination to be provided by community-based organizations set up to provide specific types of care coordination or care coordination for certain types of populations (ethnic group or chronic illness-specific groups). In this case, there must be direct bidirectional communication with the medical home. The least satisfactory care coordination is from a call center in the RCCO.

- Many medical homes relate to multiple RCCOs and they want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, they could receive a pmpm from all of them, which would enable them to afford to hire enough care coordinators to meet the needs of all of their ACC patients.

- Medical homes are willing to do care coordination, because they have a relationship with their patients. They trust them. Coordinating complex medical care is essential for good care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the

patient's life and how important those non-medical factors are on the patient's health and health issues.

- The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- On a regular basis, RCCOs should share the RCCO's performance on KPIs, share savings incentives and share with the medical home how their own performance compares with other medical homes.
- Functions: No function of a RCCO should look different from one RCCO to another from the perspective of the customer, specialists, providers, patients, and families moving from one place to another. If the service touches a customer it MUST look and feel the same such as accessing services, contacting services, receiving services. Internally RCCOs can be different, but a customer should never hear "that is not my practice, we don't do that, or you will have to call this number."

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

All RCCOs should have their offices in the region served, should be non-profits and be incorporated only in Colorado.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

- This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for <u>all</u> of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

- The first RFP was looking for different approaches from the different RCCOs. Now, we think uniformity would be more important and the basics of administration and service provision should be mandated by HCPF and all RCCOs adhere it.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County.

- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

Improve attribution, decrease the time lag for data (not four months behind) , provide for the ability to pull reports on particular topics. Stop making changes that the medical homes have to make. Allow them some time to catch up with current expectations.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

- There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

- Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) **What role should RCCOs play in attributing clients to their respective PCMPs?**

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) **What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?**

- The attribution system continues to be flawed and the process of getting patients reattributed to the correct medical homes is still very onerous. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- In the RFP, ask RCCOs how they can help improve processes for correct attribution and simple, easy correction of mis-attribution.

- Hold more patient/parent/family client focus groups.

40) **What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?** The RCCOs all do things very differently which is confusing for medical homes with patients in several RCCOs. RCCOs. RCCOs are very inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). And they are very variable from one RCCO to another. So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and response to requests for help more consistent.

- Feedback from RCCOs regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and was there improvement?

- And there are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) **How should the Department structure stakeholder engagement for the ACC as a whole?**

Maintain Advisory groups, but use them for advice instead of reporting activities to them. These groups must be active participants and their view points be seen supportive and helpful. They may have ideas to make the program better. Use these folks as subject experts and advisors instead of once a quarter meeting attenders.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population? NO

a. If no, what are the gaps?

Hospitals are not participating. They all must participate to make this effort work successfully.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities. Children and their families are not a sub population, but currently are being treated that way. The emphasis has been going to "where the money is" to keep the RCCO functioning. If you want to put an emphasis on whole person preventative care, look at your youngest members and don't think of them as a sub-population. They are the majority of your members.

44) **ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.**

a. What role should hospitals play in the next iteration of the ACC Program?

Hospitals should be incented to communicate better with medical homes. They should have significant financial disincentives to see Medicaid patients with minor problems in their emergency departments.

b. What role should pharmacies play in the next iteration of the ACC Program?

Pharmacies should be rewarded for arranging training for their pharmacists and technicians in cross-cultural communication, providing translation services and providing extra teaching for families with limited health literacy.

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

The Healthy Communities personnel should be functionally merged with the RCCOs to enable better coordination and reduce duplication of efforts

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) **How can RCCOs help to support clients and families in making and keeping appointments?**

Should be done in the practices part of the Care Coordination iand the PMPM should be sufficient to support it.

46) **Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?**

No, if we provide Care Coordination at the practice level, the practice needs to decide how is is going to do that. CHWs are a good choice if paired with others. PMPM should be enough to defray the expenses of CHW.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐

On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) **Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?**

- Maintain accurate up-to-date listings of dental providers accepting Medicaid.
- Assist dentists in applying for Medicaid credentials

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

The Joint Commission has identified the following 3 challenges as the "triple threat" to healthcare communication: 1. Language barriers 2. Cultural barriers, 3. Low health literacy barriers.

b. What RCCO requirements would ensure cultural competency?

RCCOs should contract for training for their staff and the personnel in medical homes to receive training regarding:

- Cultural barriers to good health outcomes and how to address them
- Cross-cultural communication
- Addressing limited English proficiency in clients
- Addressing limited health literacy
- Each RCCO must have a comprehensive strategy to address effective communication (oral and written) with limited English and culturally different patients/families as well as those with low health literacy.
- What is your "organization's" strategy for addressing the triple threat on these three levels:

- Building awareness of the "triple threat" to healthcare communication (1, 2, and 3 listed above)
- Identifying and addressing systemic solutions to health literacy (signage, website readability, handouts, phone trees, communications to patients, care coordination).
- Implementing education/training for providers and staff in private practice and clinic settings in your region to improve communications skills that lead to better health outcomes for all patients.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

- Understanding Cultural barriers to good health outcomes and how to address them
- Cross-cultural communication
- Addressing limited English proficiency in clients
- Addressing limited health literacy

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) **Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?**

- Pay medical homes even higher reimbursement for after-hours care than you do now.
- Pay emergency departments at a lower rate than medical homes for patients with minor problems.
- Require co-pays even for children. But waive the co-pay if they called their medical home first.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐

Provide chronic care	☐	☐	☐	☐
	☐	☐	☐	☐
	☒	☐	☐	☐
-management tools	☐	☐	☐	☐
ucational materials about specific conditions	☐	☐	☐	☐
	☐	☐	☐	☐
-screening tools	☐	☐	☐	☐
	☐	☐	☐	☐
-screening tools	☐	☐	☐	☐
	☐	☐	☐	☐
-competent care	☐	☒	☐	☐
raining on motivational interviewing	☒	☐	☐	☐
ools and software for phone call and appointment	☒	☐	☐	☐
for tracking labs, referrals, etc. Provide referral and	☒	☐	☐	☐
ns of care checklists	☐	☐	☐	☐
	☐	☐	☐	☐
rectory of community resources	☐	☐	☐	☐
	☐	☐	☐	☐
naterials regarding Nurse Advice Line	☐	☐	☐	☐
ll tools and resources are centrally located on RCCO-	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

Nurse line – the Medicaid nurse line number is on Medicaid cards. The Medicaid line does not communicate with the medical home about calls or referrals to emergency departments. The Medicaid nurse line undercuts the medical home. The patient should call their medical home.

There are so many programs being funded to provide practice support, SIM, CHES and now TCPI, I believe the question is not what to provide, but how does the ACC fit into what is available to practices and not flood the practices with helpers from each for these initiatives. How can the programs work in collaboration with a single goal in mind and split up the work? All the tools and supports are great, but the process of helping practices will not be welcomed if the programs look uncoordinated and non-collaborative. Let's work together.

templates

Provide registries

Offer client reminders
Offer client self

Supply behavioral health surveys
Supply other self
Administer behavioral health surveys
Administer other self
Prepare client action plans
Provide training on providing culturally
Provide training to supporting staff

Provide tools and resources

Provide visit agendas or templates
Provide standing pharmacy order templates
Provide comprehensive di Provide
directory of other resources

specific website

Others 54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

See Above

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

- The current "Enhanced Medical Home Standards" and the well child visit KPI are sufficient.
- The more incentives, the less of an incentive they create.
- A pmpm is also ok; but attribution is very flawed which serves as a disincentive

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

Shouldn't be required, because it could be expensive for the small medical home and would likely require double entry of information. So, it could be recommended and incented. HCPF or RCCO would probably have t provide registries for smaller medical homes that are compatible with the medical home's EHR.

58) Please share any other advice or suggestions about provider support in the ACC.

The ACC is headed toward capitation. It would be important for HCPF to open codes now to encourage services and activities you want medical homes to provide later under capitation, so medical homes establish the habits now and so frequency of the services and fair reimbursement can be determined prior to switching to capitation. For example, socialemotional screening in toddlers and preschoolers should be reimbursed now.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high performing medical home has no way of knowing who is low performing. This idea shows a

lack of understanding of the world where health cares is delivered. Medical homes need to receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

- Since children are the majority and give the best chance of truly improving health and wellness, KPIs need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-forservice, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully. Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state should already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it moves to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

RCCOs should be sure that medical homes that meet their key performance measures or other targets should receive their full share of incentive payment even when the RCCO as a whole has not met its performance targets.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-

time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and provider from medical homes to develop a vetting process that will enable HCPF and RCCOs to trust medical home self-reported realtime data.

- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd.

Appropriate child health measures could be selected from the following measures :

- Well child visits appropriate for age
- Developmental screening by three years of age
- Teen depression screening
- Complete immunization status by age two
- Post-partum depression screening rate for mothers of newborns by age 4 months
- Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
- Patient (or family) satisfaction ratings
- Documentation of QI projects

- Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate

outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

66) Measuring Client experience. Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	☐	☐	
Please type your response here.			

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, 5DAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and provider from medical homes to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd.

- The following measures should be used to measure outcomes for children:
  - Well child visits appropriate for age o Developmental screening o Teen depression screening

- Complete immunization status by age two
- Post-partum depression screening rate for mothers of newborns by age 4 months. o Appropriate antibiotic use in URI and strep pharyngitis

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

The PCMP or medical home should receive real-time data (less than a month since date of service) that will allow them to compare their performance with performance of similar type of medical home.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☒
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Because many medical homes have patients in more than one region, the KPIs should be the same for all regions. The RCCOs and the PCMPs should have the same KPIs. The medical home should receive incentive payments for reaching its targets even if the RCCO did not reach its target KPIs.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Both. The best incentives are those that give health care providers targets to shoot for AND reward progress

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

Real time data that is accurate is crucial for rapid cycle quality improvement in medical homes and in order to provide incentives that will motivate medical homes. This means data available within 2-4 weeks rather than 4-6+ months. The SDAC data comes too late to: (1) support rapid cycle quality improvement and comes too late to provide meaningful incentives. Both family practices and pediatric practices report that the SDAC is still inaccurate compared to the medical homes own data that they obtain from their EHR, or their claims-based data. Many medical homes these days are able to capture the data needed by HCPF and the RCCOs within a week or two of service, rather than 4+ months later. We recommend that the ACC develop a process for self reporting of data. We realize that HCPF would need to vet the quality and accuracy of practice data, but please consider this.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication**. For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☒
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☐	☒
Smartphone app	☐	☒
Other: ALL formats are necessary to address specific needs that the other formats cannot; that's why they're there.		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐

Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the 5DAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☒	☐	☐	☐
Care management tool	☐	☐	☒	☐	☐
Care transitions alerts	☒	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☒	☐	☐	☐	☐
Health risk assessment software	☐	☒	☐	☐	☒
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☒

Patient education wellness tools	☐	☐	☒	☐	☐
Provider/case manager directory	☐	☒	☐	☐	☐
Shared decision-making tools	☐	☒	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☒
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

- Technology to improve the performance of Primary Care Practices
- Possessing outdated tech (eg Windows XP, Office 2003), or next-to-no tech at all
- Inability to use basic office management software (ie MS Office)
- The Attribution algorithm is faulty; FIX IT. KEEP ADULTS OUT OF PEDIATRIC PRACTICES
- Liability anxieties create inter-agency barriers related to sharing PHI
- Releases are not standardized across Medicaid entities.

81) How can Health Information Technology support Behavioral Health Integration?

- 5ystems are needed for tracking
- Improving assessment and identification of needs that lead to/exacerbate behavioral health issues
- Reducing duplication of work; increasing real-time connections between providers
- Improving security, enhancing communication, reducing cost, increasing user satisfaction

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

YES. Needs to have more data and greater end-user flexibility. It should allow end-user customization to accommodate diverse needs

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

YES. System could be similar to BUS, TRAILS, EPIC, etc. Standardization is VITAL to ensure consistency across providers, regions, and to improve audit efficiency

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

Standardization is VITAL to ensure consistency across providers, regions, and to improve audit efficiency

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

- Require HCPF to include more data and end-user functionality in the SDAC.

- Update ALL data every month (disregard 120-day timely filing delay).
- Make HCPF fix the attribution algorithm; incorporate pediatric practice information to eliminate attribution of adults to pediatric rosters.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

- Standardized, regular, ADT info from hospitals
- Standardized ROI for use by all Medicaid entities.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

- Assistance (one-on-one, classes, over-the-phone, web-based) on using parts of the SDAC; post TREO's SDAC webinar
- Education, consultation on encryption, transmission, and storage of PHI

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

- Sharing of real-time ADT data
- Need to include small and single-provider practices as well

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

"No Practice Left Behind"
Many providers lack the skills to implement anything but the simplest of electronic activities. Population health management involves use of technology that many (most?) do not possess. RCCO's are well-placed to help the providers in their areas improve, as a group, toward more effective population management.

Appendix: Definitions and Acronyms

The following words have been defined for the purpose of this RFI.

42 CFR is a federal regulation outlining when information about someone's Substance Use Disorder (SUD) treatment may be disclosed with or without his or her consent.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 070

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Brad Young
Location: 3660 Wadsworth, wheat Ridge, CO 80033

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Pharmacists Society
Location: 6825 E. Tennessee Ave.#440 Denver, Colorado 80224

☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☒ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☐ Yes
☒ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
CPS in conjunction with RxPlus, Pfizer and GSK, have met with all 7 RCCOs to discuss how pharmacy can best serve the needs of each RCCO. A Pharmacy Stakeholder Report documenting the interactions and responses is attached to this e-mail.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
CPS has worked closely with Colorado Medicaid on the current pricing methodology for pharmacy. We also have communicated and lobbied on Medicaid issues impacting the Pharmacy program

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Colorado Pharmacists Society, RxPlus Pharmacies and chain pharmacies have been advocating a more active role for pharmacists in the RCCOs for several years. We believe that since patients see their pharmacists more regularly than other health care providers, community pharmacists are in a unique position to provide comprehensive medication

☐ Since before the program was implemented.

management, which has been demonstrated to help with adherence, improve transitions of care, and provide patient education and counselling. We would like to play a more active role in that capacity. Many pharmacies are using newly developed telecommunication tools that are designed to assist in that role (such as Prescribe Wellness). We continue to believe that pharmacists in all settings, including retail community pharmacists, can and should play a much more significant role in the RCCOs to help improve health outcomes for patients.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

2) What is not working well in the ACC Program?

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

b. How should RCCOs prioritize who receives care coordination first?

c. How should RCCOs identify clients and families who need care coordination?

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	
Health literacy	☐	☐	☐	
Housing	☐	☐	☐	
Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	
Transportation	☐	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	Coordinate care? No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Pharmacists should play a role in coordination and transition of care.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

Colorado Pharmacists Society, RxPlus Pharmacies and chain pharmacies have been advocating a more active role for pharmacists in the RCCOs for several years. We believe that since patients see their pharmacists more regularly than other health care providers, community pharmacists are in a unique position to provide comprehensive medication management, which has been demonstrated to help with adherence, improve transitions of care, and provide patient education and counselling. We would like to play a more active role in that capacity. Many pharmacies are using newly developed telecommunication tools that are designed to assist in that role (such as Prescribe Wellness). We continue to believe that pharmacists in all settings, including retail community pharmacists, can and should play a much more significant role in the RCCOs to help improve health outcomes for patients.

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐

Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

CPS in conjunction with RxPlus, Pfizer and GSK, have met with all 7 RCCOs to discuss how pharmacy can best serve the needs of each RCCO. A Pharmacy Stakeholder Report documenting the interactions and responses is attached to this e-mail.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offers and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☐
Care management tool	☐	☐	☐	☐	☐
Care transitions alerts	☐	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☐
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

81) How can Health Information Technology support Behavioral Health Integration?

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Comprehensive Medication Management in Regional Care Collaborative Organizations

Expanding the role of the pharmacist in the delivery of cost effective healthcare in Colorado

Presented by the Pharmacy Stakeholders of Colorado

Executive Summary, Recommendations and Findings
October 2013

Executive Summary

This document serves two purposes. First, it is a compilation of the input and feedback received in the meetings between 6 of the Colorado RCCOs and the pharmacy stakeholders. Stakeholders include: Val Kalnins, Colorado Pharmacists Society; Brad Young, Grant Kinn and Fofi Mendez, RxPlus Pharmacies; Jim Driscoll, IPC; Charlie Sheffield, Colorado Chain Pharmacies; Spencer Guthrie, GSK.

Second, it provides a review of several well documented literature resources that describe the implementation of MTM/CMM services, including those in state Medicaid programs.

The purpose of the meetings with the RCCOs was to determine the following:

- What the RCCOs are doing now as far as Drug Therapy Management
- How can the pharmacist community help the RCCO achieve its goals of containing costs and improving quality
- What would be the RCCOs ideal scenario be for the inclusion of Drug Therapy Management/Comprehensive Medication Management

Each meeting began with these questions followed by an explanation of what is Medication Therapy Management (MTM) and Comprehensive Medication Management (CMM). For the purposes of our meetings, MTM and CMM were defined as follows:

> Medication Therapy Management is the delivery of pharmaceutical care services in which the pharmacist takes responsibility for all of a patient's drug-related needs and is held accountable for this commitment.
>
> Comprehensive Medication Management takes it to the next level as a patient care service in which drug therapy decisions are coordinated collaboratively by physicians, pharmacists, and other health professionals together with the patient.

Most of the services pharmacists currently provide are MTM. CMM, which includes integration with the health care team, leads to greater cost savings and improved quality of care for the patient through the coordinated care model.

What the RCCOs are doing now? Responses included:

- Delegate care management to FQHC
- Work with patient's existing pharmacies
- Care coordinator has patients records including medication profile
- Community care teams responsible for medication utilization

How can the pharmacist community help the RCCO achieve its goals? Responses included:

- Medication reconciliation (hospital or community setting),
- Medication Adherence/compliance
- Chronic pain management/substance abuse (review of medications when multiple PCPs have been visited).
- Expansion of Medication Review beyond Prescription Drugs (non-prescription drugs, supplements and herbal products)
- Pharmacists could play a key role in the education and outreach to the patient population

What is the RCCO's ideal scenario? All of the RCCOs consider medication management an important element of health care and are performing some form of medication management. Colorado Access currently has a CMM process in place which utilizes University of Colorado clinical pharmacists, and an MTM process for some individuals performed by personnel at the University of Arizona by fax and internet. But the RCCOs were generally not aware the possibility of implementing a pharmacist-based MTM/CMM process. One of the RCCOs, however, has reached out to local community pharmacists in their Region to become involved, and was enthusiastic about including pharmacists as health care specialists. All of the RCCOs we met with asked that we supply information about pharmacies in their regions.

The common thread from the meetings with all 6 RCCOs included the following:

- It is important that the Physician knows and trusts the pharmacist providing CMM
- The MTM/CMM activities should integrate into the care management program of that particular RCCO.
- All the RCCOs use some form of medication management. None of them have a formal CMM program
- All the RCCOs were receptive to the idea of incorporating CMM
- As long as it is simple, flexible and easy to implement, no RCCOs were opposed to enhancing their MTM programs.

Each RCCO was provided with additional references and resources on the value of pharmacist services and documents concerning MTM/CMM as requested. The attached report provides links and pdf files of those documents that were requested or that demonstrated the value of pharmacist services.

The document *Improving Potient ond Health System Outcomes through Advonced Phormocy Proctice: A Report to the U.S. Surgeon Generol* was cited numerous times as the source for the corroboration of the value and cost savings pharmacists services provide. This report to the Surgeon General provides 27 pages of examples of the value and cost savings that pharmacists can provide to the health care system.

RECOMMENDATIONS:

1. We concur in part with the comments made by the Department in the response to JBC Question 34 from the JBC Hearing January 7, 2013: "The Department believes that several options exist, which, with expanded funding, could promote more effective use of pharmaceuticals, improved health outcomes, and reduced long-term costs. The expansion of the Department's Rx Review program, authorized by HB 07-1021, to a full Medication Therapy Management program, could serve the Department's clients statewide and would be a promising investment."

2. We would further suggest that the RxReview program should be enhanced into a Comprehensive Medication Management system and be made available to the RCCOs in a way that makes it possible for each RCCO to develop their own unique CMM pilot programs utilizing RxReview if they choose to do so. Such an enhancement would require an appropriation by the legislature, but would provide savings with a significant return on investment (see literature from Minnesota below).

3. The Department noted in the January JBC hearing document that if a sizable appropriation is granted they may be compelled to "use the state's competitive procurement process to procure a vendor to perform these functions." And that "Such a vendor may not necessarily be required to contract with local pharmacists to perform these reviews." Any program developed should maximize face-to-face consultations and utilize pharmacists in Colorado. Multiple vendors are available to provide the necessary technology for the implementation of a pharmacist-provided CMM/MTM program using Colorado pharmacists.

KEY FINDINGS:

- *Phormacists ore seen os voluoble members of the heolth core neighborhood teom. Fostering the phormocist/potient relotionship wos seen as a possible component that could benefit the RCCO and the potient. Community Phormocy CMM services are an optimal RCCO option when;*

    1. *The physicion knows ond trusts the phormocist doing the CMM.*
    2. *It integrates into the care monogement program os designed and operates ot the locol level.*
    3. *It does not create ony odditionol worklood for the proviclers*
    4. *The Monogement model is simple to use ond implement.*
    5. *Physicions do not see odditionol worklood bosed on phormocist recommendations.*
    6. *There ore no unfunded mondotes.*[1]

PHARMACIST VALUE ADDED FINDINGS:

A consistent theme throughout discussions with the RCCOs was their requirement that each RCCO be able to maintain its own local process while creating and maintaining the patient/provider relationship.

- Each RCCO has its own management and implementation design for care based on local needs, resources, and demand. This would also apply to CMM. Pharmacists are the most accessible and convenient health care provider.

- All the RCCO's indicated they could integrate CMM further into their systems and suggested the following as value added components to the medical neighborhood;

1. Medication reconciliation (hospital or community setting),
2. Medication Adherence/compliance
3. Chronic pain management/substance abuse (review of medications when multiple PCPs have been visited).
4. Expansion of Medication Review beyond Prescription Drugs (non-prescription drugs, supplements and herbal products)
5. Pharmacists could play a key role in the education and outreach to the patient population.

- Any medication management program that is implemented must provide a common platform that is available to all providers to use and provides flexibility for the pharmacist and the RCCO.

- Upgrade the current HCPF RxReview program. Make the program available for RCCOs as an option for medication management services. Continue to operate RxReview as a fee-for-service program within Medicaid.

KEY MTM/CMM FINDINGS OUTSIDE OF COLORADO:

The policy recommendations above are supported by a wealth of data. There is a proven track record of significant ROI with MTM/CMM and Medicaid. Data from 2005 to 2011 in Minnesota[2,3] includes managed care lives. The report states: "This study documents that from 2006 to 2011, the Minnesota DHS MTM program continued to grow each year in terms of total number of MTM visits, claims, and participating pharmacists. Claim submissions and amount of dollars compensated has followed an exponential increase during the 6 years of the program."

The National Conference of State Legislatures (NCSL) Legisbrief Vol. 18, No. 4 January 2010, (http://ecom.ncsl.org/webimages/legisbriefs/Jan2010/1804.pdf) stated the following: "Minnesota, Mississippi, New Mexico and North Carolina initiated Medicaid-based programs as early as 2003. In Iowa, Medicaid medication therapy services uncovered 2.6 medication-related problems per patient; in 52 percent of cases, a new medication was recommended, and in 31 percent, discontinuing a medication was recommended. Minnesota's services resulted in a 31 percent reduction in total health expenditures per patient, from $11,965 to $8,197, and a 14 percent increase in meeting patients' goals. The savings exceeded the cost of medication therapy services by more than 12 to 1." The NCSL report has many references that document ongoing state MTM programs.

NCSL reported in March 2012 on MTM programs in 18 states.[4] According to the report, " Yet, the Institute of Medicine's 2004 report on health literacy says 90 million people have difficulty understanding, using, and acting on health information. The problem is compounded by the fact that most patients hide their confusion from their doctors because they are too ashamed and intimidated to ask for help."

The American Society of Health-System Pharmacists (ASHP) reported on the status of Medicaid programs in eleven states that have implemented MTM programs.[5]

An October 2010 article in the publication *Medicol Core* entitled US Pharmacists' Effect as Team Members on Patient Care examined 298 studies and concluded "Pharmacist-provided direct patient care has favorable effects across various patient outcomes, health care settings, and disease states. Incorporating pharmacists as health care team members in direct patient care is a viable solution to help improve US health care."[6]

Dr. Brian Isetts, Professor at the University of Minnesota, and one of the prime authors of "Clinical and economic outcomes of medication therapy management services: The Minnesota experience"[3] has been contacted and asked for advice about how pharmacists in Colorado can help implement a Colorado Medicaid MTM/CMM program. His advice was this: "There are 3-4 times as many Medicaid recipients who walk through the doors of community pharmacies everyday, compared to their peers in clinics and clinic/hospital pharmacies.... Which gets back to my forecast for the profession of pharmacy - there will be/are two types/classes of pharmacists in this country: Those who provide CMM for patients and those who don't.... I can help those community pharmacists who really want to build CMM practices."

CONCLUSION:

The documentation on the subject is overwhelming in support of the conclusion that pharmacist-provided medication management improves patient outcomes and saves significant health care dollars.

There are multiple vendors who provide IT platforms that make it possible for pharmacists to provide CMM services.

HCPF's RxReview program could be enhanced, with a sufficient appropriation from the Legislature, to provide a robust platform for pharmacist-provided CMM services for Medicaid patients through the RCCDs employing the services of Colorado-based pharmacists.

It is clear from the literature that there is a significant return on investment. From our meetings with the RCCOs, we believe that by meeting certain criteria, the RCCOs would find pharmacist-provided CMM services to be a welcome addition to their operations.

Medicaid expansion under the ACA coupled with the PCP shortage creates an opportunity to recognize pharmacists as an easily accessible, less expensive, trusted healthcare provider for the Medicaid population. There is no other provider where the patient can walk up to the desk and receive medical care.

- The RCCO's recognize this role and are willing to be a partner in building a platform for CMM that they can use as an option.
- The RCCO's are currently exploring various MTM/CMM models at the local level.
- The RCCO's conveyed that they have "seven secret sauces" on how they are doing care management. Let's take pharmacy best practices, make it local, share what works. and make medication care management one of the key ingredients of each of the seven secret sauces.
- The patient relationship with a pharmacist is a critical component of patient care, cost containment, increased patient satisfaction and provides the RCCO with the outcomes they desire.

Footnotes:

[1]**Key findings are based on community pharmacy discussions with six of the seven RCCOs**

[2]**Adoption of medication therapy management programs in Minnesota 2006–11:** Steven Larson, Sara Drake, Lowell Anderson, and Tom Larson. Univ. of Minn. School of Pharmacy. 2013 May-Jun;S3(3):2S4-60. doi: 10.1331/JAPhA.2013.12166.

[3]Clinical and economic outcomes of medication therapy management services: The Minnesota experience Brian J. Isetts, PhD, BCPS, FAPhA; Stephen W. Schondelmeyer, PharmD, MA (Pub Adm), PhD; Margaret B. Artz, PhD; Lois A. Lenarz, MD; Alan H. Heaton, PharmD; Wallace B. Wadd, PharmD; Lawrence M. Brown, PharmD, PhD; Robert J. Cipolle, PharmD
J Am Pharm Assoc (2003) 2008;48:203-214. doi:10.1331/JAPhA.2008.07108

[4]**Medication Therapy Management: Pharmaceutical Safety and Savings**
http://www.ncsl.org/issues-research/health/medication-therapy-management.aspx

[5]**ASHP Policy Analysis: Pharmacist Provider Status in 11 State Health Programs:** Lisa Daigle, Policy Analyst, and David Chen, R.Ph., MBA, Director, Pharmacy Practice Sections,and Director, Section of Pharmacy Practice Managers: Date of Issue September 2008
http://www.ashp.org/DocLibrary/Advocacy/ProviderStatusPrograms.aspx

[6]**US Pharmacists' Effect as Team Members on Patient Care: *Systemotic Review ond Meto-Anolyses*:** Marie A. Chisholm-Burns, PharmD, MPH, FCCP, FASHP; Jeannie Kim Lee, PharmD, BCPS; Christina A. Spivey, PhD, LMSW; Marion Slack, PhD; Richard N. Herrier, PharmD; Elizabeth Hall-Lipsy, JD, MPH; Joshua Graff Zivin, PhD; Ivo Abraham, PhD, RN; John Palmer, MD, PhD; Jennifer R. Martin, MA; Sandra S. Kramer, MA; and Timothy Wunz, PhD: *Medical Care* • Volume 48, Number 10, October 2010
http://dmhc.ca.gov/library/reports/news/rci/petmpc.pdf

ATTACHMENT A

RCCO Meetings:
The Department requested that pharmacy representatives meet with each of the RCCO's leadership to discuss how the RCCO teams view the possibility of developing CMM programs. The following meetings were held:

September 4: Region 4 Integrated Community Health Partners
Donna Mills, Director Region 4;
Brad Young, RxPlus

September 19: Region 6 Colorado Community Health Alliance
Kit Brekhus and Ryan Ward from ICHP;
Val Kalnins, CPS; Brad Young and Grant Kinn, RxPlus; Jim Driscoll, IPC; Charlie Sheffield, Colorado Chain Pharmacies; and Dave Rogers from Safeway.

September 23: Regions 2, 3, S Colorado Access
Rebecca Kurz, April Abrahamson, Molly Markert, Irene Girgis, (plus other staff) from Colorado Access;
Val Kalnins, CPS; Susan Hahn, Mental Health Centers of Denver and RxPlus; David Lamb, Good Day Pharmacies and RxPlus; Grant Kinn and Brad Young, RxPlus; Jim Driscoll, IPC; Fofi Mendez, RxPlus;

September 30: Region 1 Rocky Mountain Health Plans
Jenny Nate, Mike Huotari, and Julie Hoerner from Rocky Mountain Health Plans;
Val Kalnins, CPS; Grant Kinn, Brad Young, and Fofi Mendez from RxPlus;
Spencer Guthrie from GSK; Jim Driscoll from IPC; and

Attachment B
Resource Links:

Medication Management Systems (Minnesota MTM company)
http://www.medsmanagement.com/About/staff.html

Minnesota Medicaid MTM
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_136889

NACDS/APhA Model MTM Program
http://www.pharmacist.com/sites/default/files/files/core_elements_of_an_mtm_practice.pdf

National Council of State Legislatures
http://www.ncsl.org/issues-research/health/medication-therapy-management.aspx

APhA report on MTM by Lewin 2005
http://www.accp.com/docs/positions/commentaries/mtms.pdf

Academy of Managed Care Pharmacy: Pharmacists As Vital Members of Accountable Care Organizations; 2011
http://www.amcp.org/aco.pdf

APHA Medication Management Therapy Digest: Pharmacists Emerging as Interdisciplinary Health Care Team Members; June 2013
http://www.pharmacist.com/hub-policy-and-advocacy-june-2013

Medical Care • Volume 48, Number 10, October 2010: US Pharmacists' Effect as Team Members on Patient Care
http://www.ncbi.nlm.nih.gov/pubmed/20720510

Surgeon General's Report 2011
http://www.usphs.gov/corpslinks/pharmacy/documents/2011AdvancedPharmacyPracticeReporttotheUSSG.pdf

This acknowledgement from the U.S. Surgeon General's report best summarizes why the pharmacy stakeholders of Colorado are convinced that the services the pharmacists of Colorado can provide to the RCCOs will be in the best interest of the RCCO and their patients.

"Through the delivery of patient care services, pharmacists improve outcomes, increase access to services for medically underserved and vulnerable populations, improve patient safety, shift time for physicians to focus on diagnosis and more critically ill patients, improve patient and provider satisfaction, enhance cost-effectiveness, and demonstrably improve the overall quality of health care through evidence-based practice."

Colorado Department of
Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 071

Accepted by: KJDW

Notes: Standard cover sheet added; formatting standardized

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Kathi Wells & Bill Betts
Location: Statewide

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Program to integrate healthcare for children in foster care
Location: Statewide
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Pediatrics
  ii. Area of practice: Foster Care
☒ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☐ Yes
☒ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Developing healthcare services for children in foster care all of whom are enrolled in RCCO

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Historically majority of services are paid through Medicaid fee for service. Have integrated behavioral health services into practice but experiencing barriers to behavioral health funding that are not seen for physical healthcare.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

We have no choice if we are going to serve this population.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

Historically, children foster care have frequent moves between healthcare providers with inadequate sharing of healthcare information. It was mandated that the RCCOs specifically address the healthcare needs of children in foster care. Therefore the promise of RCCOs, is that they can ensure children in foster care receive the specialized healthcare services that need, which the RCCOs can demonstrate through data on outcomes. RCCOs can assist in the development of a consistent medical home for these children, who have complex healthcare needs because have the ability to coordinate and direct where children in foster care receive services. However, it is currently unclear whether this potential is being realized consistently across the state.

2) What is not working well in the ACC Program?

It is unclear whether the ACC has provided guidance to the RCCOs on how to manage the unique healthcare needs for children in foster care. Many times there are a number of individuals (foster parent, child welfare case worker, guardian ad litem/courts) that have a role in ensuring that children get the healthcare that they need. Often RCCOs lack the infrastructure to ensure all parties are provided with the information that they need. While the RCCOs have care coordinators, these individuals are sometimes unaware of how the child welfare system functions and which individuals need to be contacted under specific situations. In addition some parts of the state, specialized services have been developed for children in foster care however the attributing process is often unaware of these services. Therefore, children foster care are not able to benefit from these resources. Also, some children in foster care experience frequent moves. The ACC system is not well designed to address information sharing when children move between providers and/or RCCOs.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

This varies between BHOs. For example Access Behavioral Health makes it easy to contract for behavioral health services.

4) What is not working well in the BHO system?

In some areas it is difficult to contract for services (especially for specialized care- which is often needed for children in foster care). In some areas this means developing a single case agreement which can take up to 3-4 weeks. In other areas, BHOs refuse to contract for services. This is especially problematic for children in the child welfare system since they may enter the system in one area and get placed in a foster home in another. This means that which BHO is responsible can be difficult to determine.

5) What is working well with RCCO and BHO collaboration right now?

It is not clear what is working well. This does not mean that nothing is working, just that it is not clear to providers in the community.

6) What is not working well with RCCO and BHO collaboration right now?

Since medication is managed by one system and psychotherapy is managed by another, there is often a disconnect between these two closely related services. Additionally, the BHO and RCCO areas are different. This is further complicated by the fact that they do not overlap with areas for other parts of the system (such as judicial districts). This causes difficulty and confusion when trying to determine which agency to contact.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☒	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☒	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☒	☐	
RCCO or BHO contracts	☒	☐	We currently work with a medical team but as behavioral health providers we cannot always see the individual that the medical team sees.
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

There is far too much for it to be listed here, but much of this guidance can be found in the Medical Home literature.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Because the carve out of behavioral health dollars, many families find that they can get healthcare anywhere but are barred from behavioral health services. For example, my behavioral health clinic is tied to a large hospital. Individuals with Medicaid can get healthcare from the hospital, but are unable to get behavioral health services because the BHO in the area refuses to contract for behavioral health.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

b. How should RCCOs prioritize who receives care coordination first?

c. How should RCCOs identify clients and families who need care coordination?

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	
Health literacy	☐	☐	☐	
Housing	☐	☐	☐	
Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	
Transportation	☐	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

I have a hard time saying that RCCOs should absolutely have a role or not have a role. If any of these things have an impact on health care, they should be addressed, but I do not believe for example that issues of abuse neglect or trauma should be routinely addressed

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	

Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Again, I think that care for individuals varies, in some cases only one of these professionals will be involved, and by default will do case coordination. In cases where there are a variety of professionals involved, it is important that a primary person be selected to serve as the primary care coordinator. Which of these professions takes on this role will depend on the needs of the individual.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☐	
Children	☒	☐	
Children who are healthy, but in socially-complex environments	☒	☐	
Children involved in the foster care system	☒	☐	
Children with a chronic illness	☒	☐	
Children with a serious emotional disturbance	☒	☐	
Children with medical complexity	☒	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	
Transition-age adolescents	☒	☐	
Parents and families	☒	☐	
Pregnant women	☒	☐	
Adults	☒	☐	
Adults who are healthy, but in socially-complex situations	☒	☐	
Adults with a chronic illness	☒	☐	
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	
Clients involved in the criminal justice system	☒	☐	
Clients with a disability	☒	☐	
Clients in a nursing facility	☒	☐	
Elderly clients	☒	☐	
Frail elderly clients	☒	☐	

Clients in palliative care	☒	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

RCCOs should ensure high quality healthcare (including medical, dental and behavioral health) for children in foster case, while in no way impeding the care they get from other systems. The problem with this statement is that it is an enormous and complex process to do this and to try. A whole committee of experts could work for years to develop recommendations around this, and it is unlikely that any answer written on this survey could adequately sum up this complex issue.

19) How should care coordination be evaluated? How should its outcomes be measured?

Again there are national standards published for this.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐

2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Providers in each region should be asked to rate the RCCO. RCCOs that do not have sufficient support should be at risk for losing their contract.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

It is not so much that the either the RCCO or BHO maps should change, rather that the maps are different. There the map for BHOs are different from RCCOs and for that matter are different from maps for DHS (child welfare), judicial districts, Departments of public health, etc.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

No

a. If no, what are the gaps?

There is a disconnect for children in the foster care system.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

Yes

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☒	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☒	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

Yes

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Specific measures of behavioral health symptoms. We are not being reimbursed

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☐
Care transitions alerts	☐	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☐
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☒
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Cost

81) How can Health Information Technology support Behavioral Health Integration?

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

Routine reports of effectiveness should be shared. Data should be made available (with appropriated safeguards/confidentiality) to health researchers for studies specific issues of health.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 072

Accepted by: KJDW

Notes: Standard cover sheet added; demographic page added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Colorado Society of Anesthesiologists
Location: City, County, State.

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Click here to enter text.
Location: City, County, State.
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☒ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Colorado Society of Anesthesiologists

Are you currently involved in the ACC program?

☐ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Click here to enter text.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

COLORADO SOCIETY OF ANESTHESIOLOGISTS
4582 S. Ulster Street Parkway, Suite 201, Denver, CO 80237 ▪ 303-770-6048 ▪ 303-771-2550 (fax) ▪
www.csa-online.org

November 24, 2014

Kevin Dunlevy
Department of Health Care Policy and Financing
Accountable Care Collaborative Strategy Unit
1570 Grant St.
Denver, Colorado 80203-1818

Re: ACC RFI

Dear Mr. Dunlevy,

The Colorado Society of Anesthesiologists (CSA) would like to submit the following response to the Request for information. With over 700 physician members the CSA represents the interests of the practicing anesthesiologists in the state of Colorado. The Perioperative Surgical Home is a concept that has been developed by the American Society of Anesthesiologists (ASA) to address the need for increased care coordination with the goal of improving patient safety, quality care, and achieving cost efficiencies in the health care system.

We believe that the Perioperative Surgical Home concept addresses the stated goal of the Accountable Care Collaborative to provide "a client and family-centered, whole-person approach that improves health outcomes and ensures savings". This model of care would dramatically increase coordination of the perioperative care of the patient, from the time a decision is made to have a surgical procedure, through the hospital course of treatment, and then through the postsurgical rehabilitation period. Initial studies have demonstrated significant improvements in the patient experience of care, decreased costs, reduction in postoperative infections, targeted preoperative testing, fewer transfusions, shortened hospital stays, and fewer hospital readmissions when anesthesiologists are actively engaged in the entire continuum of perioperative care.

Attached is an informational overview prepared by the ASA that provides additional detail regarding the Perioperative Surgical Home. The CSA also intends to submit this concept in its response to the Colorado Department of Health Care Policy and Financing request for proposals for a targeted rate increase for 2015.

We look forward to the opportunity to discuss this innovative care management model with the ACC. The CSA is committed to working collaboratively with the ACC to improve the delivery of health care to the Medicaid patient population.

Sincerely,

Murray S. Willis MD

Murray S. Willis, M.D.
President

Principles of the Perioperative Surgical Home

BACKGROUND

Surgical patients require preoperative testing and preparation, anesthesia, specialized nursing care, postoperative recovery and rehabilitation, in addition to the surgical procedure itself. Perioperative care accounts for 60% of hospital expenditures. Although advances in medicine have increased safety, perioperative patients are at risk for bleeding, infection, blocked blood vessels or thromboembolism, and other hospital-acquired conditions. At present, multiple physicians, typically working independently, manage these patients, often creating inefficiencies in care delivery and increased risk for adverse events. The PSH integrates the care of surgical patients from start to finish throughout the health care system. The PSH improves patient experience, promotes overall health, and reduces costs. Additionally, the PSH aligns with legislative intent for alternative payment models.

PSH PRINCIPLES

Care is coordinated and/or integrated: The overall perioperative care will be coordinated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services).

Preoperative evaluation: Each patient presenting for surgery will go through a standardized preoperative evaluation and appropriate medical management of underlying medical conditions to decrease the risk of the perioperative experience. The preoperative phase will have a strong focus on an excellent patient experience as demonstrated by a straightforward and easy to understand process supported by educational materials.

Intraoperative medical practice: The PSH would ensure greater consistency in anesthetic, surgical and nursing care and protocol-based patient management during surgery.

Postoperative management: The team will particularly focus on the management of pain, nausea and vomiting, and reducing the incidence of the most common postoperative complications. The goal is to optimize patients' return to their overall normal function, with minimized morbidity.

Quality and safety is ensured through the following:

- PSH coordinates patient care to support the attainment of optimal, patient-centered outcomes that are defined by fully coordinated pre-operative, intra-operative and postoperative care driven by a compassionate, robust partnership between physicians, non-physician healthcare workers, surgical facilities, and patients.
- Surgical Care shall be evidence-based and clinical decision-support tools will guide decision-making.
- Physicians are accountable for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in education, risk modification strategies, and shared decision making, and feedback is sought to ensure patients' expectations are being met

- Information technology is utilized appropriately to support optimal patient care, performance measurement, coordination with all providers and facilities, patient education, and as the basis for enhanced communication
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate they have the capabilities to provide patient centered surgical care consistent with the Perioperative Surgical Home.
- Patients and families participate in quality improvement activities at the practice level.

Surgical care is advanced by establishing a single point of contact for preoperative, intraoperative and postoperative care. Care is enhanced through transparent scheduling, expanded pre-op clinic access hours and new options for communication between patients and their PSH care team.

Payment appropriately recognizes the added value provided to patients by the PSH. The payment structure should be based on the following framework:

- Reflects the value of physician and non-physician patient-centered care management work that is a part of the direct care but also the work that falls outside of the face-to-face visit.
- Pays for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- Supports adoption and use of health information technology for quality improvement.
- Supports provision of enhanced communication access such as secure e-mail, web-based e-visits, and telephone consultation.
- Recognizes the value of physician work associated with email and other non face-to-face care technologies, including patient education, e-consent and other innovative approaches to care.
- Allows for separate payments for extraordinary care visits. (Payments for perioperative services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- Allows physicians to share in savings from reduced surgical complications, length of stay, value-based resource utilization, and other metrics developed that reflect better care.
- Allows for additional payments for achieving measurable and continuous quality improvements.

Learning Collaborative

ASA announced it has chosen Premier, Inc. (NASDAQ: PINC), a leading health care improvement company, to develop a first-of-its-kind learning collaborative for the ASA's PSH model of care. ASA's PSH learning collaborative will proactively pursue care redesign strategies seeking to enhance the surgical patient's experience, improve quality and outcomes, and reduce costs. This includes better care coordination to reduce length of stay, readmissions, and complications. The ultimate goal is to create an evidence-based "road map" for other health care organizations to spread knowledge and best practices of the PSH model.

For more information visit the PSH website at http://www.periopsurghome.info/index.php

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 073

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Click here to enter text.
Location: City, County, State.

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: KPCO Colorado
Location: Denver, CO
☒ **Please check if you are answering on behalf of this entity**

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Primary and Specialty Care
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☒ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

Two key aspects of the ACC stand out as the most effective and valuable for integrated care delivery systems like KPCO: the ACC's focus on establishing medical homes for Medicaid clients; and the access to data afforded by the Statewide Data Analytics Contractor (SDAC). These elements complement KPCO's focus on preventive care, and enables providers to anticipate the needs of the most complex clients within the ACC. The ability to partner with RCCOs to coordinate care of Medicaid clients directly allows KPCO to provide its Medicaid members with many of the benefits of an integrated model. However, there are constraints that prevent PCMPs from readily establishing connections to hospitals serving Medicaid clients (e.g. timely communication to PCMPs regarding Medicaid clients' emergency room visits and admissions is not yet reliable and consistent). While KPCO does not have care management delegation agreements with all the RCCOs, they are in place for the great majority of KPCO's Medicaid members. Furthermore, the ability of PCMPs to both receive and access data in the SDAC helps KPCO evaluate its performance as a PCMP, and obtain risk scores of its Medicaid clients to plan how various care needs will be met.

2) What is not working well in the ACC Program?

The current structure of the ACC does not allow Medicaid clients to realize the full benefits of an integrated health care delivery system like KPCO, In significant part due to the fee-for-service payment methodology. As a PCMP, KPCO's integrated approach aligns with the ACC vision for whole person care—yet the current fee-for-service reimbursement causes challenges for KPCO as it looks to invest resources that address both medical and social needs of Medicaid members. For instance, the work of KPCO's Community Health Specialists, which were specifically resourced to address the non-medical, social needs of KPCO's Medicaid population, does not translate into codes that are reimbursed by Medicaid. However, the work of these Community Health Specialists contributes to KPCO's ability to drive positive health outcomes for Medicaid clients.

Moreover, when KPCO's Medicaid clients access care outside of KPCO, it is challenging to receive timely information relevant to addressing clients' health needs. Finally, while there is ongoing work to improve the disjointed nature of the current RCCO and BHO structures, facilitating effective communication and coordination to meet the behavioral health needs of clients continues to be a challenge.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

Through its developing partnerships with the BHOs, KPCO has appreciated the flexibility of the BHOs to work with PCMPs to establish effective care coordination workflows. The BHOs have largely delegated coordination of care to the community mental health centers (CMHCs). As referenced below, execution on the part of the CMHCs can be fragmented.

The Denver Boulder and Northern Colorado BHOs are very interested in contracting with KPCO for integrated behavioral medicine services, and contracting discussions underway, with one contract nearing completion (Access Behavioral Care). The BHOs have also expressed an interest in contracting for Substance Use Disorder Treatment services, which will further enhance efforts to integrate physical and behavioral health care.

4) What is not working well in the BHO system?

The carve-out itself presents significant challenges for PCMPs that work to help secure access to behavioral health for Medicaid clients, as it requires specialized knowledge of BHOs and community mental health centers (CMHCs), whose enforcement of regulations vary. Not only do workflows/interpretation of regulations differ across BHOs, they differ across CMHCs within the same BHO, which, at times, makes it very difficult to coordinate care. Providers from one KPCO medical office may have Medicaid members from three BHOs and as many as 4-5 CMHCs, each with different procedures as to how the Medicaid member should access services (whether urgent or routine). Due to variances in the interpretation of HIPAA regulations among CMHCs, sharing protected health information to treat patients that PCMPs and CMHCs have in common presents challenges. For instance, medication reconciliations do not occur in as streamlined and efficient a manner as possible to meet patient needs. This is especially true when a new patient presents to his/her KPCO provider with multiple co-morbidities, including recent psychiatric history. Reconciliation of all current medications, including psychiatric, is not only fundamental to the PCMPs' diagnostic formulation and medication recommendations, it is critical to the process of addressing care needs. Lastly, access to psychiatric services at the CMHC can be 60-90+ days out, with some CMHCs not having the ability to bridge psychiatric medications until they can be seen by the CMHC prescriber.

5) What is working well with RCCO and BHO collaboration right now?

As a PCMP, KPCO has not had experience with RCCO and BHO collaborations, but has collaborated with BHOs on behavioral health matters, and separately with RCCOs on primary and specialty care.

6) What is not working well with RCCO and BHO collaboration right now?

Please see the response to question five, above.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Moving toward behavioral health integration must include incenting and otherwise encouraging PCMPs to provide behavioral health services, and/or establish clear pathways for PCMPs to collaborate closely with behavioral health providers. The current carve-out presents obstacles for PCMPs to provide behavioral health services to Medicaid clients in primary care settings, while the coordination across the ACC and BHO structures is also challenging, as described in responses to questions 2 through 5 above.

KPCO is committed to provide the same level of fully integrated care to Medicaid members as its commercial members. The behavioral health carve out makes this endeavor challenging. It will be important to address the issues described above from an administrative level, rather than expecting the PCMP to work with each CMHC to develop workflows that fit the individual CMHC. The issues range from expectations and accountability related to access for psychiatric appointments to standardized workflows for sharing protected information within HIPAA guidelines.

KPCO is an active participant in the State Innovation Model (SIM) planning efforts. SIM has an ambitious goal of connecting 80% of Coloradans with coordinated systems of care that give them access to integrated behavioral health care in primary care settings. KPCO has demonstrated its success in this arena with its commercial members, and are invested in ensuring realizing the same success with Medicaid members.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services. Using the table below, please explain which issues are barriers, and how they can be addressed:**

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	The BH carve out presents structural care issues that make seamless care difficult for larger integrated health systems (e.g. KPCO) serving Medicaid members.
Community Behavioral Health Services Rule	☐	☐	No opinion.
Covered diagnoses list	☒	☐	Excluding certain disorders (e.g. neurodevelopmental) creates a 2 tiered system.
Different behavioral / physical health reimbursement	☒	☐	Moving reimbursement methodology toward risk-based, capitated payments for physical health to make it more consistent with behavioral health reimbursements, and allow for shared risks and savings.
Institutions for Mental Diseases exclusion	☐	☐	No opinion.
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	No opinion.
PCMP financing structure	☒	☐	Aligning reimbursement methodologies between physical and behavioral health.
Per-member per-month amount	☒	☐	Aligning reimbursement methodologies between physical and behavioral health.
Physical space constraints	☒	☐	Limited existing physical infrastructure reduces capacity to build the best space plan to support integrated care (pods, etc.).
Privacy Laws (HIPAA, 42 CFR)	☒	☐	Need to ensure that the HIE addresses the issues effectively.
Professional / cultural divisions	☒	☐	Training and demonstrating value/ROI of integrated care should address this.
RCCO or BHO contracts	☒	☐	BHO carve out creates barriers to fully integrated care for Medicaid patients in integrated health systems – contracts/collaborations between RCCOs and BHOs could mitigate these challenges.
Staff capacity	☒	☐	Workforce development needed to train integrated staff (Primary Care and

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

			Behavioral Health). Limited numbers of appropriately licensed staff (including Substance Use Disorder treatment staff) presents issues. This needs to be addressed on a number of levels, including at the graduate school level.
State/Federal rules or reporting requirements	☒	☐	Though this has eased somewhat, there needs to be increased focus on reporting that is essential to document the services that are provided, vs. a one-size-fits-all approach.
Technical resources / data sharing	☒	☐	Lack of technical ability to share medical/behavioral health information in real time is a challenge.
Training	☒	☐	See above.
Others	BHO structure requires a multi-BHO PCMP to set up a s a fee-for-service provider across several different BHOs with different billing/auditing requirements in order to provide on-site behavioral health services, and bill. It would be helpful if it were possible for PCMPs to bill Medicaid directly for some mental health services without having to bill the BHO separately.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physicai and behavioral health care?

- The patient/famiiy is in the center of the team.
- Shared decislon making with the patient and family.
- Health care providers (Px and BH) are on the same team (BH inciudes Substance Use Disorders), focused on a common popuiatlon.
- Shared Electronic Medicai Record.
- Joint treatment/services plannlng with shared goals with the patient, health care providers, and social workers/community specialists.
- Common workspace.
- Positive overall health outcomes of the individuai/the whole person is the common focus.
- Population Management and Chronic Disease Management are a focus (including complex, high risk, high cost patients).
- Data informed decision making, with outcomes tracking.
- Supports are provided to patients/famiiies to help address heaith care disparities, health outcomes and access.
- Integration of inpatient and outpatient services.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

Care coordination is deliberately organizing patient care activities, inclusive of addressing nonmedical/social needs, and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.

b. How should RCCOs prioritize who receives care coordination first?

All members should receive care coordination according to need/risk. RCCOs should establish both real time (for instance, for discharge notifications) and retrospective processes (i.e. high utilization systems, claims, risk stratification) to determine need and subsequent receipt of care coordination. Additional indicators that trigger real time care, such as sudden missed appointments, should further inform prioritization of care coordination.

c. How should RCCOs identify clients and families who need care coordination?

Please see the response to (b) above.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

Medical providers should provide counts to RCCOs of clients receiving care coordination, and continue to require regular reporting. The outcomes of care coordination should be the focus of RCCO tracking activities. At times, the current approach seems to emphasize staffing levels and program features over outcomes.

12) What services should be coordinated and are there services that should not be a part of care coordination?

KPCO's integrated care delivery model includes coordination of services, such as: Emergency Department utilization, behavioral health, transportation, financial challenges, chronic disease management, end of life issues, transitions from hospitalizations, prevention services, home health, Durable Medical Equipment, and medications. While securing resources for nonmedical/social needs can be challenging, care coordination services should also include connecting Medicaid clients to resources that address such needs as housing, food insecurity, and legal issues.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

Lists of active medications, recent hospitalizations and discharge summaries are a few of the important pieces of information consistently utilized by KPCO clinicians to address care coordination needs. Population analytic reporting also supports both disease and prevention services. In addition, information regarding where Medicaid clients live provides insights into potential for in-home assistance, and could inform approaches to care coordination.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

KPCO's integrated care delivery model includes coordination of the following services: Emergency Department utilization, behavioral health, transportation, financial challenges, chronic disease management, end of life issues, transitions from hospitalizations, prevention services, home health, Durable Medical Equipment, medications, and more. Most, if not all, care coordination for KP Medicaid members occur with KP care coordinators that share a single electronic medical record (EMR), and can effectively coordinate communications through the shared EMR. Care coordination as an activity expands beyond the title of care coordinator, and any care coordination activity for a member conducted by a KP clinician is documented in the shared EMR.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

The only systemic outside care coordination activity that occurs today is with Behavioral Health (BH) services for ACC Medicaid members. Because the BH services do not occur in shared EMR the communication, coordination of care can be difficult. KPCO makes an effort when possible to incorporate external BH service information into the EMR, and shares relevant clinical information with BHOs/CMHCs when requested.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

Creating a cross functional platform that can communicate with all multiple systems, and consider subsidizing a compatible EMR system for practice sites seeing a majority of ACC members. Also, securing contracted payment arrangements to augment fee-for-service payments would help clearly delineate ownership of care coordination responsibilities.

d. What are the gaps in care coordination across the continuum of care?

Fee for service structure makes it difficult to determine utilization of members across systems. Members can choose to see any participating provider, and utilization information does not pass easily between systems.

15) RCCOs' roles in addressing clients' and their families' non-medical needs. Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☒	
Affordability (assistance with	☒	☐	☒	Provide actual monetary assistance to members.

prescriptions or co-pays)				
Daycare / childcare	☐	☒	☒	
Economic stability & employment	☐	☒	☒	
Education	☐	☒	☒	
Environment	☐	☒	☒	
Food access / nutrition	☒	☐	☒	Health classes, dietician consultations
Health literacy	☒	☐	☒	Health classes, self-management classes
Housing	☐	☒	☒	
Language or translation services	☒	☐	☒	Documentation should be translated, conversations with members should be using translation services
Literacy	☐	☒	☒	
Transportation	☒	☐	☒	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please expiain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	Develop APN/RN run clinics, Group visit approach, lead Interdisciplinary team (IDT) care coordination.
Certified Addiction Councilors	☒	☐	Referrals as appropriate. Share information.
Certified Nurse Midwives	☒	☐	Develop APN/RN run clinics, Group visit approach, lead interdisciplinary team (IDT) care coordination.
Community Health Workers	☒	☐	Coordinate meeting social care needs.

Generalists (BA/BS/MA/MS)	☒	☐	Coordinate meeting social care needs.
Heaith Coaches	☒	☐	Work in community/home environments
Licensed Clinical Sociai Workers	☐	☒	Referrals as appropriate. Share information.
Licensed Marriage and Family Therapist	☐	☒	Referrals as appropriate. Share information.
Licensed Mental Health Counselors	☒	☐	Referrais as appropriate. Share information.
Licensed Professionai Counseior	☒	☐	Referrals as appropriate. Share information.
Masters of Public Heaith	☐	☒	Referrais as appropriate. Share information.
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	
Nurse Practitioners	☒	☐	
Patient Navigators	☒	☐	Integrate components of medicai and social care
Peer Advocates	☒	☐	Group visits, house calis/check-ins
Promotoras	☒	☐	
Psychiatrists	☐	☒	Share information.
Psychologists	☐	☒	Share information.
Registered Nurses	☒	☐	Coordinate group visits, act as a facilitator for IDT, manage whole-person care, and chronic disease managment
Social Workers	☒	☐	Coordinate across continuum of care, inciuding sociai.
Wraparound facilitators	☒	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the tabie below to describe if any of the foliowing populations require unique care coordination requirements, or if generai requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☐	Post natal care, iactation consuitation
Children	☒	☐	immunizations, well-chiid visits
Children who are healthy, but in socially-compiex environments	☐	☒	Assessment for safety
Children involved in the foster care system	☒	☐	Assessment for safety

Children with a chronic illness	☒	☐	Disease management
Children with a serious emotional disturbance	☒	☐	Behavioral health services
Children with medical complexity	☒	☐	Complex care management
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	Access to addiction prescriptions
Transition-age adolescents	☐	☒	
Parents and families	☐	☒	
Pregnant women	☒	☐	At risk mother coordination
Adults	☒	☐	Prevention reminders (crc screening, mammography, etc)
Adults who are healthy, but in socially-complex situations	☒	☐	Assess social needs
Adults with a chronic illness	☒	☐	Disease Management and Care Coordination
Adults with a behavioral health diagnosis or substance use disorder	☐	☒	
Clients involved in the criminal justice system	☐	☒	
Clients with a disability	☐	☒	
Clients in a nursing facility	☐	☒	
Elderly clients	☒	☐	Fall prevention, cognitive screening, functional status assessment,
Frail elderly clients	☒	☐	End of live and Palliative care referrals
Clients in palliative care	☒	☐	Care Coordination, ensure appropriate access
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

Create RN/MSW liaison teams within RCCOs and the foster care system to ensure necessary care coordination and appropriate resource utiiization.

19) How should care coordination be evaluated? How should its outcomes be measured?

HEDIS metrics, CRC screening, HBA1C control rates, 30-day readmission, ED utilization, Inpatient utilization, hypertension control rates, total cost of care, etc.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

As an integrated system, KPCO spreads costs of care, including care coordination services, across our entire membership. It is therefore challenging to quantify the exact cost for providing care coordination services to Medicaid clients. However, connecting PMPM reimbursements for care coordination to risk scores would help to account for the complex care coordination needs of clients. Also, under the current care management PMPM, it is unclear how to respond to high-utilizing members who decline to engage with primary care, or who might benefit from home-based, high-intensity interventions. Perhaps this can be addressed through a combination of RCCO involvement and changes in PMPM reimbursement structure.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

Yes, due to variable costs of care by population, it would be advisable to vary PMPMs accordingly.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

No, as it is not easy to determine a general ratio because care coordination activities are often specialized according to specific populations (i.e. diabetes Care Coordinators, palliative care coordinators, asthma care coordinators, complex care coordinators, perinatal care coordination, behavioral health coordination etc.). Organizations should staff care coordination based on the risk of their specific population, with a focus on health outcomes and total cost of care rather than prescribed general ratios.

a. Care coordinator to client ratios. If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

HEDIS metrics, CRC screening, HBA1C control rates, 30 readmission, ED utilization, inpatient utilization, hypertension control rates, total cost of care, and patient satisfaction data (and/or data that includes input from Medicaid clients).

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Care coordination activity should be focused on overarching quality outcomes. Determining the direct correlation between care coordination activity and its effect on outcomes is challenging. KPCO relies heavily on evidence based best practices informed by literature review as a guide to determine how to deploy care coordination activity. In the health care system, any client experiences is vast and complex, and drawing correlation or causation of improved outcomes to any one activity, including care coordination, is difficult. However, it is clear that when care coordination activities are monitored and maintained, overall quality of outcomes improves for members.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

As a PCMP providing services to Medicaid clients across all seven ACC regions, KPCO also serves as the delegated entity for care coordination duties in four of the seven regions. While the delegation agreements with Colorado Access and the Colorado Community Health Alliance (CCHA) are similar, the requirements, and associated deadlines, differ, and each RCCO has multiple meetings on similar topics around best practices and program or policy changes, which places a strain on resources. KPCO recommends care coordination delegation continue to be standardized, along with reporting requirements. Guidelines for RCCOs on what types of responsibilities can be delegated, with a corresponding range of PMPM payments would also be helpful, as it would help to make negotiations between PCMPs and RCCOs transparent and consistent. Further, for any program initiative that provides incentive payments for PCMPs through an evaluation of the PCMP capabilities (such as the enhanced primary care provider program), a standardized evaluation process that meets the requirements of all RCCOs would help prevent unduly burdensome and redundant work for PCMPs that work with multiple RCCOs. This process should allow PCMPs that meet the requirements in one RCCO to demonstrate that they meet the requirements for all RCCOs through one standardized evaluation. Similarly, PCMPs could be stratified by level and receive standard reporting directly from the Department, rather than doing several similar data requests with each RCCO that would need to be combined.

There is also a consistent challenge to provide coverage for the multiple meetings convened by each RCCO. If the meetings could be combined or categorized in such a way that multi-regional PCMPs could attend one of each type of meeting, or attend the meetings on some kind of rotation, PCMPs could dedicate their valuable time and resources to addressing pressing needs in the administration of the program.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Specific examples that demonstrate a bidder's capabilities in building and strengthening community relationships should be required. Also, previous experience as an ASO, health plan, or other entity with experience developing provider networks for Medicaid or commercial plans would be valuable. A strong understanding of potential contract arrangements between PCMPs, specialists, and the RCCO is essential. New RCCOs, as suggested in this RFI, could be required to contract directly with providers to create a preferred provider network.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

If this proposal would allow PCMPs like KPCO, with a presence across all regions, to consistently and efficiently address the administrative requirements of the chosen RCCOs, KPCO would be in favor of this proposal. As noted above, accounting for, and responding to, the different ways that each RCCO approaches its duties drives significant work for PCMPs that work across multiple regions. Moreover, if RCCOs were set up as health plan-like entities, responsible for contracting, developing, and maintaining a provider network, the ability of

the PCMP to choose a RCCO with which to contract would naturally follow from this structure. PCMPs would select the RCCO that most directly supports their needs such as data transfer, member hand-offs, etc.

27) Should the RCCO region maps change? Why or why not? if so, how?

KPCO does not have specific recommendations regarding how the RCCO or BHO region maps are drawn. However, the difference between the RCCO and BHO maps cause additional administrative issues as we coordinate the care of Medicaid members. Therefore, KPCO recommends aligning the RCCO and BHO maps. Also, utilizing state data on public transportation and health care access, the travel patterns of families should also be a consideration in defining logical region definitions that will make it easy for members to access services.

28) Should the BHO region maps change? Why or why not? if so, how?

Please see answer to question 27, above.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

An amount of time that does not exceed 12 months seems reasonable for a seamless transition. However, because KPCO lacks experience serving as a RCCO, and the capabilities and approaches of RCCOs vary, it is difficult to know the appropriate number of months for a successful transition. Apart from the number of months, it would be important for the transition to include comprehensive knowledge transfer that allows the new RCCO to learn from, and reference, the experience of the outgoing RCCO. if RCCOs take on more functions like network development, contracting, and maintenance function, a more lengthy transition may be required.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

Policy and rule changes that would achieve the following outcomes are recommended:

- Create a referral requirement in the ACC to allow improved coordination of care and utilization management.
- Adjust/modify policies to help align Medicaid to coverage available through Connect for Health Colorado to facilitate transitions between different types of health care coverage.
- Allow for hospital risk to be included as part of integrated PCMP risk-bearing payment methodologies to connect investments in primary care, including preventive care, to outcomes.
- Update the Medicaid provider enrollment application and process to include requirements for access and appointment availability.
- Adjust/modify policies to help coordinate Medicaid with coverage available through Connect for Health Colorado to reduce simultaneous enrollment.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

While Medicaid benefits seem quite comprehensive, there are two challenges: 1) The structure does not reimburse for many preventive care services that lead to positive health outcomes; and 2) It is unclear to

Medicaid providers and clients alike what the Medicaid benefit package includes/excludes. A standard evidence of coverage document for Medicaid members would make the obligations of Medicaid and providers clear to members, and let them know what is available in way that aligns with coverage documentation in the commercial world. Additionally, a defined benefit package would provide a template for integrated PCMPs like KPCO to develop a benefit plan, create provider relationships to meet that plan, and enter into partial or full risk capitation payment models.

Retroactivity for Medicaid eligibility, while not directly connected to the benefit structure, creates challenges as primary care providers that serve members covered with commercial coverage as well as Medicaid. Among the challenges are determining the benefit package of individuals who are enrolled in an Exchange coverage product, and are retroactively enrolled in Medicaid. This situation may also result in members experiencing a taxable event for the period of dual eligibility. Moreover, retroactive enrollments create challenges for providers and health plans that increase administrative costs, and adversely impact the member experience.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

The transition of the RCCOs from a regionally-based entity to a more flexible structure would not only allow more bidders to participate, it would potentially give Medicaid clients more choice regarding their health care. Having multiple RCCOs would also simplify provider contracting so that geographically based barriers would not create the need for additional contracts with other agencies. Also, having multiple RCCOs per region should provide the State with improved comparative performance information.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

This question is not applicable to KPCO.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

PCMPs like KPCO need to be able to plan and budget for new Medicaid client attribution. This makes the transparent, consistent and automated attributing of clients an important RCCO responsibility. Also, to improve client satisfaction, it would be helpful if the RCCOs could develop and use neutral criteria to assist Medicaid clients with PCMP selection. Alternatively, providing Medicaid clients with a choice to choose a RCCO and/or PCMP at the time of application could aid in enhancing client choice while aligning with practices/policies for coverage available through Connect for Health Colorado.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

Public health data sets that may help the ACC Program better understand the health status of Medicaid clients and the needs of communities should be shared between CDPHE and the ACC Program. Such exchange of data may then lead to initiatives that combine public health and health care practices to improve health outcomes.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

The development of the Colorado PEAK website is an excellent example of how streamlining eligibility processes for programs that benefit similar/same populations can increase and ease access to helpful resources for vulnerable populations. Given the similarities between the populations served by the ACC Program and CDHS, additional collaborations that ease access to resources is encouraged. One specific area that could benefit from an ACC/CDHS collaboration is around foster care transitions. As a PCMP, KPCO has experienced challenges learning of issues related to foster care transitions to inform the care planning process.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

It would be helpful to have regular data from both the ACC Program and Connect for Health Colorado that demonstrates the real-time membership churn between Medicaid and the Exchange. As much as possible, a former commercial member's health plan should inform their passive enrollment into a RCCO, and PCMP selection in the ACC. Unless the Medicaid client chooses otherwise, and whenever possible, the client should be attributed to his/her previous CHP+ plan or previous Exchange provider. This would greatly enhance continuity of care. On the other side, when members transition from Medicaid to the Exchange, the Exchange customer service representatives should have access to information regarding which RCCO and PCMP the individual previously accessed in the ACC Program, and then help explain available plans with similar networks.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

If RCCO entities become responsible for the development and direct contracting with preferred provider networks, they may need to work with DORA/DOI. The ACC Program and DORA/DOI should collaborate to ensure that any new, related requirements on the RCCOs are understood, and met without causing undue administrative burden on the RCCOs.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

There continues to be opportunity to help stakeholders understand the role of RCCOs, as well as the support they can provide. Offering a clear and consistent explanation of the services and support RCCOs provide to Medicaid clients and their families will support continued success of the ACC. Some suggested approaches include:

- Develop a fact sheet for client advocates that can be shared with outreach workers and enrollment specialists. This fact sheet might include an explanation of how the RCCO supports service delivery as well as medical and non-medical referrals.
- Develop a client mailing/insert that identifies the clients' RCCO that can be included with the Medicaid card mailing.
- Provide Medicaid case workers with a RCCO contact to refer clients to when they have questions specific to access.
- Include a RCCO contact phone number on the Notice of Action communication generated by CBMS. This would be an additional number to the existing case worker contact, and would help clients know to call their RCCO (and not their case worker) for questions specific to access.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

Much of the successes of the ACC Program can be attributed to the involvement of local communities. To ensure appropriate and inclusive representation of required stakeholders, RCCOs could develop a newsletter or other communication tool that aligns with current methods of communication and engagement to provide updates to all stakeholders that want to be engaged. This option, along with a feedback email address, may provide additional opportunity for stakeholders to participate when attending meetings is not possible. It may also be helpful to replicate the liaison line that the CHP+ program has for stakeholders, which is a dedicated contact for community organizations that support CHP+ members.

41) How can enhanced community engagement be created in the ACC?

The Department has many established statewide relationships with organizations serving and assisting Medicaid clients through multiple departments (eligibility, policy, safety net, etc.). There may be opportunity to leverage existing communication channels among these departments to enhance engagement through a collective approach.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Given the additional health coverage options available through Connect for Health Colorado (C4HCO), it would be beneficial to leverage and align with the C4HCO Assistance Network for future stakeholder engagement efforts. Given many households are eligible for mixed coverage options, this approach may

help support continuity of care for clients. In addition, consistently leveraging existing Department communications tools (ACA Implementation, At a Glance, and Provider Bulletin) may support stakeholder engagement for the ACC.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behaviorai health providers, hospitals, pharmacies, dentai, home heaith, and non-medical providers adequately serve the ACC popuiation?

Because KP is an integrated deiivery system, we are abie to provide most services Internaiiy, and we have arrangements in piace to augment gaps with external providers. However, we stiii experience some gaps with access. Whiie the RCCOs have worked to bring provider groups together, and emphasize the vaiue of the ACC program and the need for serving Medicaid ciients, there are stiii challenges in ensuring providers are avaiiabie and willing to meet the needs of the Medicaid population.

a. If no, what are the gaps?

One significant gap involves the inconsistencies between the "open" and "closed" status in the MMiS, and whether a provider or specialist wiii actuaiiy see a Medicaid member in a timeiy fashion. Most Medicaid providers ieave their panel status as open, and take all the ACC members who attribute to them, but there is a wide disparity among providers for appointment availabiiity. To our knowiedge, appointment availabiiity within Medicaid is not measured consistentiy, if at aii.

Contributing to this gap is the difference between Medicaid payment rates and those of commerciai carriers. Commercial carriers offer competitive rates, and aiso require contracted physiclans to maintain an access standard.

Medicaid could aiso add incentives/requirements for providers who participate in Medicaid to meet some ievei of access standards as a condition of participation.

b. Please address gaps for the population as a whoie, and for specific subpopulations such as children/families and individuals with disabiiities.

From a primary care perspective, popuiation needs may drive a different array of services, but the overaii challenges across the network remain the same. To truly function as a primary care medicai home, it is incumbent upon us to develop reiationships with speciaiists that are commonly needed among our patient panei demographics. As a heaith plan, this ability to meet and maintain services for our population is measured by a series of contractual requirements and periodic audits. The data measured is not contained in ciaims, but is contained in other metric systems we have developed for this purpose.

44) ACC Ciients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What roie should hospitals play in the next iteration of the ACC Program?

Lack of timeiy information about clients seen in the EDs, and who have been admitted, continues to cause chaiienges in providing appropriate follow up in Primary Care. RCCOs, along with hospitals, should deveiop a standard data sharing agreement for post-hospitai and post-ER discharge to share that information reai-

time with PCMPs. Perhaps if hospitals collected PCMP information at check-in for Medicaid clients, they could then share information directly with the PCMP without needing the RCCO pass-through.

Hospitals could also align with the goals of RCCOs and PCMP to avoid non-emergent use of the ED and avoidable hospitalizations.

b. What role should pharmacies play in the next iteration of the ACC Program?

As an integrated delivery system with built-in pharmacies at all clinics, KPCO often uses pharmacy information to add members to disease registries and plan targeted interventions. The more data we can receive about members who have filled their prescriptions through outside pharmacies, the more accurate our care coordination and disease management will be. (see HIT request for complete claims data feed).

Also, it is worth noting that the differences between Medicaid's formulary and KPCO's formulary are challenging. For instance, Medicaid recently made a change to several ADHD medications requiring brand name products rather than generic. KPCO is different from other pharmacies in that we typically do not carry both. The product that is carried is the preferred KP agent. This requires us to order in the medication, often leading to delays in filling the prescription as well as waste of unused products. If possible, KPCO would like to have the ACC Program allow flexibility for providers like KPCO to administer the Medicaid pharmacy benefit similar to CHP+, in which the formulary and utilization tools are owned and managed by KP.

Additional challenges within the current pharmacy structure, which KPCO would like to see addressed in the next iteration of the ACC, include: 1) The PA process, which can also take several days to over a week to get a response, and leads to delay in drug therapy; 2) Lack of notification to clients of policy changes, which puts the pharmacies in the position of having to explain Medicaid's rationale and goals of the changes.

c. What role should specialists play in the next iteration of the ACC Program?

Please see question 43. Specialist Medicaid Provider enrollment should include a requirement for availability to Medicaid patients, perhaps in the form of a metric that is monitored, and a mechanism to ensure Medicaid members are provided access to care in a timely manner. On the incentive side, specialists could be paid a PMPM to participate in a RCCO network on the condition that the provider ensures Medicaid clients access to care a timely manner. Specialists could also contract directly with RCCOs and be part of a RCCO provider network. KPCO also recommends a referral requirement within the ACC to increase the effectiveness of PCMP interventions, as well as prevent self-referrals to providers.

d. What role should home health play in the next iteration of the ACC Program?

There should be improved data sharing between RCCO and PCMPs regarding the home health plan of care.

e. What role should hospice care play in the next iteration of the ACC Program?

Hospice services would significantly augment existing services, and they should be included in the ACC Program.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

For questions d through f, KPCO generally recommends that there be improved data sharing between RCCOs and PCMPs to allow for more effective care coordination and care planning.

g. What role should counties play in the next iteration of the ACC Program?

Due to the lack of understanding regarding the role counties currently play in the ACC Program, and KPCO's experience KPCO has in working directly with counties, KPCO does not have an opinion on this question.

h. What role should local public health agencies play in the next iteration of the ACC Program?

Please see the answer provided in question 35 regarding collaborations between CDPHE and the ACC Program.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

Community Organizations are helpful resources who know first-hand the nature of the provider network in their area. KPCO partners with these organizations in other efforts related to charitable health coverage. Community Organizations, if willing, could help members choose a PCMP in their neighborhood that meets their needs.

45) How can RCCOs help to support clients and families in making and keeping appointments?

Providing resources to remind clients and families of upcoming appointments, with enough lead time and information to make transportation arrangements, would be helpful. KPCO's experience shows that challenges in making and keeping appointments often stems from non-medical needs for support, such as transportation and after hours care options. It would be helpful for RCCOs to invest in these supports.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

KPCO's experiences with Community Health Workers has been positive, and would therefore find value including them in the next RFP in some way. Currently, KPCO employs Community Health Specialists to address non-medical/social needs of its members.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☒
On staff (salary) at	☒

Primary Care Medical Provider Clinic	
On staff (salary) at RCCO	☒
Per Member Per Month Payment	☒

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

Providing support for both Medicaid clients and PCMPs who may need assistance connecting to oral health providers would be an important function of the RCCO. The support could consist of providing up-to-date lists of providers accepting Medicaid clients, and as needed, scheduling appointments with oral health providers.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

To KPCO, providing a culturally competent system of care means ensuring that members' cultural needs are considered and respected at every point of contact. The delivery of health care services should acknowledge and understand cultural diversity in the clinical setting, respect members' health beliefs and practices, and value cross-cultural communication.

b. What RCCO requirements would ensure cultural competency?

Adopting the National Culturally and Linguistically Appropriate Standards (CLAS), which provide a framework for all health care organizations to best serve diverse communities, would help ensure cultural competency.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

Providers and staff should be able recognize the cultural beliefs, attitudes and health practices of diverse populations, and use that knowledge and evidence to prescribe the best possible intervention at the systems level or at the individual level.

d. Low health literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

In addition to the responses to (b) and (c) above, RCCOs should collaborate with community organizations to create or leverage member materials that help simplify and translate health care information into plain language. While requiring that member materials are available at a certain reading level can be helpful, these standards can vary, and working with organizations that understand the communities in which they are embedded is valuable and important. Also, the Health Insurance Marketplace within the Centers for Medicare

and Medicaid 5ervices has created materials for health care consumers ("From Coverage to Care") that could be distributed by RCCOs. The materials can be accessed at https://marketplace.cms.gov/technical-assistance-resources/c2c.html.

50) 5hould the next RFP allow for preferred networks for speciaity, faciiity, or ancillary care?

Yes, as such preferred networks wouid aid PCMPs like KPCO better coordinate and manage the care of its Medicaid members. Currently, Medicaid members' visits to providers outside of KPCO are not consistentiy communicated. As a result, KPCO is limited in its ability to understand the full health care history of its Medicaid members, which in turn can limit how well providers can address members' care needs.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

On a national level, KPCO's focus on preventive care, and its capabilities as an integrated health plan and care delivery system, have led to positive outcomes that include decreases in emergency room utilization. in fact, Kaiser Permanente's national data shows that KP consistently has iower ER utiiization in Medicaid popuiations, and in general, has ER utilizatlon at about 50% of the national average. Allowing integrated systems and/or other providers that have successful track records in decreasing emergency room utiiization to maximize their influence and impacts on client care couid help the ACC address the trend of increasing emergency room utilization. Outside of Medicaid, key factors that allow KPCO to impact emergency room utiiization include access to urgent care, and timely follow-up following members' emergency room visits. These visits are noted In a shared system that allows KPCO's care coordinators to quickly follow up with members, determine the health concerns that led them to the emergency room, and manage their issues going forward to prevent future emergency room visits.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

5ince the implementation of the Affordabie Care Act, more Coloradans have access to the health insurance modei of heaith care delivery. This model includes payment of monthly premiums, and forms of cost-sharing (coinsurance and co-payments). The difference between this model and the Medicaid delivery system (no premiums) make the transition between Medicaid and commercially availabie pians challenging. 5pecificaiiy, the drastic financial adjustments from very low to no cost health coverage to $100-$200/month out-of-pocket obligations are difficult. KPCO encourages the ACC Program and Connect for Heaith Colorado to coilaborate in educating consumers of these differences, and help faciiitate transitions by aiigning language/terms, and policies, when possibie.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☒
Provide practice-specific data reports	☒	☐	☐	☒
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☒	☐	☐	☒
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☒	☐	☒	☒
Administer other self-screening tools	☒	☐	☒	☒
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturaliy-competent care	☐	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☒
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others	• Help (up-to-date directory; live support) finding specialists currently accepting Medicaid. • See also note at top of following page, and response to question 55.			

Note: The responses on the previous page highlight the supports that would be *most* helpful to large, integrated delivery systems working to tailor care to meet the need of Medicaid and low-income members. "No" boxes have therefore been left unchecked.

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

Behaviorai health surveying and self-screening should use standard, validated, widely used tools such as the PHQ-9, global self-reported health status; and SF-12 health survey.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

Priority supports include providing comparative practice-level performance data (item 6); supplying actionable data about clients (providing registries, administering health/self-screening surveys); and providing tools to help rapidly locate resources to meet clients' needs that can't be met by the practice itself (emphasis upon quality/currency) rather than comprehensiveness.

Training for selected staff members who then provide internai system-wide expertise would also be helpful. Finally, consultative support in identifying best practices for delivering care to Medicaid and low-income populations.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

A basic monthly risk-adjusted PMPM amount coupled with additional incentive payments for achieving triple-aim outcomes at the individual practice level.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

Yes. However, given the current structure of Medicaid and frequent movement between providers, practice-level registries will need to be supplemented by registries provided by the state.

58) Please share any other advice or suggestions about provider support in the ACC.

Providers in the ACC would benefit from support aimed at streamlining referral processes; facilitating the exchange of care plan/treatment information and clear pathways for addressing very-high-need clients or clients who are unwilling to engage with their PCMP.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

The payment structure of having providers on a primarily fee-for-service basis with a moderate capitated basis and small amounts withheld for incentive purposes supports some, but not all, of the goals of the ACC. The incentives for meeting goals around emergency use, readmissions, and high cost imaging partially support the overall cost savings goals. Possible additional linkages could be implemented to tie the incentives more directly to the PCMPs that contribute to cost goals in addition to goals related to improving quality and the overall health of the clients.

Risk arrangements that include hospital and outpatient services, in addition to physician services, would create great opportunities for savings. At this time, the unpredictability of the costs of certain high cost drugs warrants their exclusion from risk arrangements.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

Yes, KPCO would be interested in pursuing a capitation arrangement rather than a fee for service structure. The structure of such an arrangement would be most beneficial if the arrangement and capitation amounts were tied to overall cost of providing quality care to the members in relation to the fee-for-service providers rather than upon an aggregation of services coded by the PCMP. In order to provide care in the most appropriate venue and provider, the capitation should include both primary care and specialty care to allow for the most appropriate use of resources.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

If the value is defined to be not only the direct cost associated with providing the care, but also includes the overall long term health of the members, then such an environment and infrastructure does exist.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

Kaiser Foundation Health Plan of Colorado is licensed by the DOI.

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

The payments to the providers should be based in some part on the contribution that they made to the overall success of the program, rather than as aggregate group in total.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

No Additional Comments

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

HEDIS measures should be incorporated into the payment structure for each PCMP to ensure that the higher performing PCMPs are recognized for the quality of care provided.

66) Measuring Client experience. Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	The use of CAHPS is preferred for measuring the satisfaction since it can provide a consistent basis for comparison.
SF-12 Health Survey	☒	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☒	☐	
Focus groups	☒	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

The claims data could be utilized via risk scores to measure and evaluate the populations that are being served by providers. Additional screening and mining of the data can be used to inform long term medication management.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

KPCO has been supplying data to its RCCO partners according to care delegation contracts (see also response to 24). Colorado Access RCCO has been sharing a performance report (P3) that shows benchmarks among PCMPs. This report has been a helpful tool in understanding KPCO performance compared to other PCMPs in the region, and standardizing this report across RCCOs may be a good way of sharing performance between the RCCOs, and to the public.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☒
11-20	☐

21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☒
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

A single core set of KPIs should be used across all RCCOs in order to ensure consistent comparisons. Minimal additional RCCO specific measures could be added to address specific considerations unique to those RCCOs. Providers should be paid based upon a different set of KPIs that are within their direct control and contribute to the overall success of the program.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

RCCOs should be reimbursed based upon national standards. As a Health Plan, KPCO devotes significant resources to the completion of NCQA certification and HEDIS metrics. Allowing these significant efforts to also be recognized by the ACC would be an efficient way to measuring quality without adding new metrics or manual processes.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

Yes.

74) Incentive payment frequency. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☒
Quarteriy	☒
Annuaily	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

A more specific understanding of how the RCCO structure and requirements might change wouid help Inform a response to this question.

76) For practices and community providers, what are you currently measuring to assess the quality of your care deiivery? Are you being reimbursed on any of these measures?

HEDI5 measures are currently being used to measure quality.

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	1 No, I wouldn't use	2	3	4	5 Yes, I would use
Phone call / phone number	☐	☒	☐	☐	☐
Text message	☒	☐	☐	☐	☐
Web portal	☐	☐	☒	☐	☐
Email	☐	☐	☒	☐	☐
Telemedicine / Video chat	☐	☐	☒	☐	☐
Face-to-face meeting	☐	☒	☐	☐	☐
Smartphone app	☒	☐	☐	☐	☐
Other: Click here to enter text.	☐	☐	☐	☐	☐

Nationally, KP is developing and implementing innovative health IT solutions that improve quality, access to care and convenience to its nearly 9 million members.

Preliminary information shows KPCO's telemedicine initiatives increase access to health care services, while enhancing patient convenience and satisfaction.

Electronic medical Records (EMR's) email, web portal, and smartphone apps are all currently available at KPCO to all members as well as traditional face to face appointments.

KPCO's integrated care delivery model ensures patients have easy access to appropriate care and information at all hours, there are multiple points of entry to the system, and providers are culturally competent and responsive to patients' needs.

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☒	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☒	☐
Practice assessment tools	☒	☐

Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory		
Telemedicine software	☒	☐
Other: State of the art online pharmacy refill system, mail order delivery.	☒	☐
Other: Smartphone applications	☒	☐

79) Importance of technology by type. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☒	☐
Care transitions alerts	☐	☐	☒	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☒	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☒
Practice management tools (scheduling, billing)	☐	☒	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☒
Patient education wellness tools	☐	☐	☐	☒	☐
Provider/case manager directory					
Telemedicine	☐	☐	☒	☐	☐
Other: Click here to enter text.	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

The key barrier is inconsistency among practices. KPCO uses the same system across all of its primary and specialty care providers, and also provides some of this access to contracted external providers. However,

Medicaid members may self refer to a provider or hospital that does not share data with our network. If they do share with a program such as CORHIO or the APCD, the interface of that data with KPCO's does not necessarily directly lead to appropriate follow-up interventions without manual translation of the data. KPCO would support the development of a standard data sharing protocol for use by all Medicaid providers. This would ensure that post-visit data is available for all Medicaid members regardless of provider.

81) How can Health Information Technology support Behavioral Health Integration?

Improved data sharing between BHO, RCCO, and PCMP for referrals to the BHO and receiving pharmacy and care plan follow-up data back from the BHO.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

The need was identified by KPCO to gather more data related to Medicaid patients to better understand cost impact and utilization to support efforts to improve service.

- A consistent and reliable claims direct feed linkages with the proper data elements to allow for secure data flow from State and SDAC data sources. Trustworthiness (Confidence in the data)
- Complete documentation of procedures, construction, process, and data elements (Data Dictionary)
- Claims data to reflect external as well as internal encounters.
- Historical and current data selection available through dropdown choice.
- Business goals for reliable data access improve clinical effectiveness and member/patient satisfaction.
    - Improve clinical quality of care
    - Improve patient safety and reduce medical errors
    - Improve wellness, prevention and disease management
    - Understand physician profiles and clinical performance
    - Improve customer satisfaction, acquisition and retention

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

Yes. A shared care management tool could include:

- Primary, specialty, and inpatient care workflows
- Complex case management
- Medical cost trend analyses and benchmarking of performance
- Population segmentation
- Identification of patient-specific gaps in care and opportunities to reduce cost of care while maintaining or improving quality
- Profiling of provider quality-of-care and cost-efficiency
- Bundled payment analytics
- Disease management and care planning
- Ensure that the essential data elements are accurately conveyed to the receiving practitioners in a timely and accurate manner

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

Yes. A shared population management tool would include:

1. Development of patient lists that incorporates claims, pharmacy, utilization, disease state, care coordination activity, demographics, primary care, labs, and more.
2. Ability to develop outcome metrics for a given population, i.e., diabetes control rates, CRC screen rates, etc.
3. Two-way communications between various systems including EMRs, care coordination software, and utilization management tools.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

- Online, with a designation of whether actively accepting members
- Average wait times for specialist appointments.
- Ability for users to flag providers for deletion for reasons such as: no longer participating, no access.
- Ability for users to report issues with providers such as fraud and abuse.
- Ability for providers to include some details about practice.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

A consistent and reliable claims direct feed with the proper data elements to allow for secure data flow from State and SDAC data sources.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

KP.Org currently provides a web portal for clients to connect with (email) most providers, view most test results, and get help on a variety of topics.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

RCCOs could act as a consulting partner for data elements to secure data feed setup, and assist with troubleshooting. Additionally, RCCOs could:

- Offer support through web, email, and telephone.
- Provide support webinars
- Provide documentation, data dictionary.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

See response to 80 above. These organizations could evolve into a web-based platform for providers to share after-visit information among other Medicaid providers.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

For enhanced PCMPs such as KPCO, a direct data feed of all Medicaid data, with an onboarding consultation with Medicaid claims data experts to help integrate Medicaid claims data into our existing data warehouse, would help us to more comprehensively address members' needs by improving our ability to plan interventions for Medicaid clients.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 074

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Gretchen McGinnis
Location: Denver, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Access
Location: Denver, Colorado
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☒ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently invoived in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☒ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Colorado Access participated in the CRICC program that preceded the ACC and we have been a RCCO in regions 2, 3 and 5 since inception.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Colorado Access has been serving Colorado Medicaid clients since late 1995.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

The ACC program has many strengths and a number of things that are working well. The regional and population based approach has brought communities and organizations together in new ways. There is a new understanding of the data and information available and a desire to develop metrics that are meaningful and useful for all parties. A number of other benefits of the ACC program are listed below. This is certainly not an exhaustive list but some of the high points of this important program.

- *A new focus on populations and communities*
- *Opportunities for local engagement and decision making*
- *Awareness of the systems of care that exist in communities and where there are gaps in these systems*
- *Opportunities for new relationships and connections between entities*
- *New funding to support important activities – care coordination, provider supports*
- *Primary care focus and connection to medical homes*
- *Awareness from all parties that things aren't as easy as they were initially thought to be*
- *New data availability and growing understanding of data strengths and weaknesses*
- *Understanding of outcomes and how they are measured*
- *Focus on KPIs – small number of metrics*
- *Longitudinal focus of the program, overnight transformation is not possible*

In terms of coordinating with other care management entities such as SEPs - The potential to tap into additional resources, support and coordination creates an opportunity to serve the SEP client in a way we have never been able to before. The opportunity to view/have knowledge of medical/acute care elements or their long term care needs allows a greater opportunity to view the person holistically and fill in gaps (by adding additional supports/services) that would have otherwise been difficult/impossible to identify.

2) What is not working well in the ACC Program?

As is to be expected with a new program of this magnitude, the ACC program has had some challenges and there are areas in which things have been more difficult or complicated than expected. One of the most pervasive challenges in the ACC to date has been the constant rate of change and growth in the program. The overall enrollment in the ACC has grown exponentially due to Medicaid expansions and inclusions of new populations into the program which has also brought other challenges in terms of broadening the scope of the program, adding in new requirements and expectations and drawing focus away from some of the key components of the original model. As the program has grown rapidly there has been a move toward requiring more structured and regimented tasks as a means of overseeing the growing and broadening program. This directive approach is at odds with one of the most fundamental ideals of this program – that the activities that will truly drive health system change and improve health outcomes are developed and delivered at an individual level. Interventions that are unique to each patient, to each provider, to each community and to

eoch region ore fundamentol to driving chonge. The imposition of structured ouditing ond oversight functians on o model thot needs to oddress each relotionship individuolly leods to frustratian an both sides ond a sense thot a lot of time ond resources ore being spent on octivities that ore of little volue. The issue of poyment reform cantinues to be o challenge as we oll agree that the woy in which we poy for core needs to chonge but we don't hove the tools and the systems in place to test new models. The frustrotion with this con lead to misplaced ongst and creote distroctions to achieving the best results we can in our current poyment enviranment. As is noted in the RFI, the ACC program is working to transition from a medical model to a health model. In order for that to happen, all the other Deportments, agencies and groups that have been develaped to deal with the less medicol areos need to be part of the long term plonning of the ACC so thot roles continue to be clear, responsibilities are appropriotely attributed ond resaurces are expended responsibly to achieve the brooder gools. The ACC can't take an the functians of all these ather entities and so we must oll colloborate and caardinote an a statewide level to achieve this visian.

In oddition to these overorching ideos, below is o list af ather areos in which the pragram isn't functioning as well as it could be.

- *Lack of clarity about the next phose af the ACC doesn't allow for longitudinal resource plonning ond investment*
- *System limitotions moke many things mare camplicated ond resource intensive.*
- *Data sharing and coordinotion among entitles continues to be challenging and frought with different interpretations af legal and technical requirements.*
- *Brood awareness that we are oll learning what does and doesn't drive change and there will be successful efforts ond unsuccessful efforts and both ore voluable*
- *The quantitotive story isn't reflecting the quolitative story – which is mare importont? Are we quontifying the right things?*
- *Pay for performance structure doesn't oddress thot what is valuoble in the long term may not yield short term results*
- *Incrementol steps toward success oren't being meosured ond reparted.*
- *Medicaid is o populotion thot is hord to find and engoge – clients don't hove ony Incentives to update their cantoct informotion, connect with RCCOs, etc.*
- *Differing and evolving definitions of whot canstitutes care coordinotian – activities, documentation, etc.*

Finolly, it is important that the Deportment and the cammunity at lorge see the RCCOs as a system that is designed to fill in the gops in a client-centered way, individuolized to the needs of eoch persan, ond avoiding duplicatian. The brood, sweeping generalizations about what RCCO should da, ond how we should interact with ather systems could very well lead to more directive terms in our contract that would steer us further into the need to 'check the baxes', duplicote efforts, ond decreose client centeredness/individuol-need-bosed interactions.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

The BHO system is successfully corrying risk, ond ollowing locol flexibility ond discretion to effectively deploy ond fund resources ond services. The BHOs are very successful in promoting the treotment of persons with serious mental illnesses in the community. They hove been effective in reducing inoppropriote over-utilizotion of expensive hospitol services and re-investing in community bosed olternotives ond recovery services. Prior to capitotion, Colorado spent over 50% of its Medicoid mentol heolth expenditures on inpotient core, with little focus on reducing recidivism ond promoting recovery. The system hos olso been successful in building portnerships with locol entities, ond coordinoting core for members with complex needs. This is forwording the Triple Aim, ond allowing for successful integroted core efforts. Hoving director- level positions dedicoted to Integrated core ond the cross system willingness to olign behoviorol ond physicol heolth metrics hove been porticulorly effective.

BHOs with brooder networks of providers offer more opportunities for integroted core ond different models thot con be ottroctive to o brood orroy of PCMPs. There is olso o greot willingness in mony oreos for the RCCO ond BHOs to colloborote ond identify shored priorities ond projects oround integroted core. The opplicotion of teleheolth initiotives to behoviorol heolth integrotion is going very well ond will bring greoter occess to behoviorol heolth services to o brooder populotion.

4) What is not working well in the BHO system?

The current silo poyment structure is still on obstocle to integroting core for those with complex heolth needs. Increosed payment flexibility is needed to incent olternotive poyment models thot support BHOs in providing diverse models of integroted core ond core coordinotion. There ore olso remoining chollenges with the success of member referrols from the physicol heolth to the behoviorol heolth system. There seems to be on expectotion thot everyone should get integroted core but not oll members wont it/ PCMPs ore sometimes chollenged by wonting to refer clients for behoviorol heolth core but member doesn't wont to go ond sometimes members doesn't wont core coordinoted. The ongoing chollenges with doto ond informotion shoring oround behoviorol heolth doto, specificolly 42 CFR continues to be o huge issue ond reolly limits the efficiency of integroted core ond core coordinotion. The BHOs ond CMHCs olso don't hove formol roles in the ACC ond this should evolve in the next version of the ACC. Active porticipotion in shored sovings ond other outcome bosed progroms would be good ploces to moke thot connection more formol.

5) What is working well with RCCO and BHO collaboration right now?

Communicotion ond colloborotion is continuolly improving – especiolly when doto con be shored ocross systems. Providers ond core coordinotors report more ond more successes in providing effective core to members with complex behoviorol ond physicol needs os the systems support eoch other with not only clinicol expertise, but olso system novigotion, poyment ond odministrotive expertise. Teleheolth octivities ore being implemented ond ore showing positive outcomes. The presence of on integroted core leodership role in the BHO provides o good point of contoct for these projects ond efforts. There is olso willingness to olign on reporting metrics ond efficiencies of scole between the RCCO and the BHO.

6) What is not working well with RCCO and BHO collaboration right now?

While the strength noted above represents success for packets of providers and members, systematic collaboration is still a challenge. The ability of the BHO and RCCO (as well as Substance Use, Child Welfare and other service entities) to share data in real-time, provide comprehensive non-overlapping care, and realize shared savings is still limited. A finite set of covered diagnoses (versus covered services) limits the ability of BHO to support RCCO member needs, and payment structures and different contract priorities do not equally incent RCCO and BHO collaboration and integrated care. The overlap in contract requirements or lack of shared outcomes in contracts should be evaluated and approached systematically.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Poyment reform is criticol. The steps essentiol for successful core integration need to be clarified and poyment needs to be aligned with those steps- from communication to shared outcomes. As a state, we must move away from o fee for service model. The documentotion ond doto ond informotian sharing requirements must be clear ocross the state and not apen to voriable interpretation. Eorly intervention ond integroted care octivities must be encouraged and funded which is a chollenge in the current diagnosis bosed model. Further, integrotian must be pilated ocross a variety of Medical/Heolth home models. While the Primory Core Provider medical home model is importont, members should hove the aption ta create their own medicol home- which could be with a primory core physician, or within their community mental heolth center, or onother voriotion.

A number of potentiol suggestions for next steps ore listed below:

- *Allow each region ta pilot one or two mojor poyment reform trials where poyment is based on the provision af complete integrated service models.*
- *Develap a cost bosed encounter madel for integroted core based an current activities in successful models. This could be paid in oddition ta the copitoted diagnasis based model.*
- *Create o pool of funding either thraugh sovings ar some funding taken from each of the RCCO and BHO budgets thot is shored between a RCCO and o BHO in o region thot must be used jointly to develap and implement integrated core and early intervention services within the regian. Neither the RCCO or the BHO con spend any of the shored funds without agreement of the ather and integration plons need to be*

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) Barriers to the integration of behavioral health and physical health services. Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☒	☐	Limits ability to pay for integrated care and provide early intervention and preventive services before a diagnosis is present.
Different behavioral / physical health reimbursement	☒	☐	Duplicate payments for FQ encounters for behavioral and physical health the same day. Capitated model vs FFS. Capitated model allows for payments outside of fee for service model to support innovation or align incentives to achieve desired outcomes. Current ACC model doesn't allow for this.
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☒	☐	Confusion on interpretation between entities, significant legal documents required (or at least thought to be required) to allow for the coordination of care and collaboration RCCOs, BHOs SEPs and other entities have in their contracts.
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☒	☐	Lack of clear alignment of contracts, ie big focus on integrated care in BHO contract, not a specific focus in RCCO contract.
Staff capacity	☐	☐	

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

State/Federal rules or reporting requirements	☐	☐	Medicare data source needed
Technical resources / data sharing	☒	☐	RCCOs specifically directed not to share SDAC access with BHO or SEP staff, even when within the same organization. Not all BH data and/or long term care data available in SDAC to calculate total cost of care or shared savings.
Training	☐	☐	BHO finance based on covered services and co-located care; Operating inside the current system doesn't support integrated care funding; need to open codes
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Integrated care is an important solution for complex members, and RCCO and BHO systems need to be equal partners in working towards the creation of a flexible integration system. It is also important, however that integration doesn't occur at the expense of an existing mental health system that or with the complete burden on primary care practices. The mental health system is designed for, and has successfully met, the needs of an important subset of Coloradans. Mental health funding and services cannot compete against physical health funding and services. Physical and behavioral health providers must retain their specialized expertise and must be incented as complementary pieces of an overall health care system.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

At its core, care coordination should be Member/Family-Centered and individualized. Multi-disciplinary teams should be used and the model should be outcomes focused, not managed at the individual task or process level. Creativity and trial and error need to be encouraged and successes and failures transparent. Overall care management should:

-facilitate provision of comprehensive health promotion and chronic condition care

-ensure ongoing, proactive and planned care activities

-build and use effective communication strategies among family, medical home, specialists, schools, and other systems of care, support and advocacy

-build and use evidence based interventions for special populations

-help improve, measure, monitor and sustain quality outcomes of triple aim

Adapted from Jeanne W. McAllister Elizabeth Presler W. Carl Cooley

b. How should RCCOs prioritize who receives care coordination first?

Each RCCO should have a stratification model that is based on the unique needs of each community and region but allow for direct referrals. Real time, proactive data must be available to allow for the implementation of a successful stratification model.

c. How should RCCOs identify clients and families who need care coordination?

Health risk assessment results

Member/Family request

Clinic or community partner referred

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

Monitor outcomes (SDAC and other)

Chart audit

Validation of stratification methadology

Patient activation, satisfaction, health confidence

12) What services should be coordinated and are there services that should not be a part of care coordination?

It needs to be acknowledged thot no amount of core coordinotion provided by the RCCO, or ony heolth core system, will solve the culture of poverty ond resolve the life situotions thot mony of our members find themselves in. Addressing that issue is of vitol importance but there isn't one individual system or poyor that con odequotely tockle this complex and devostoting issue. The RCCO can provide valuoble support in coordinating medical, behovioral, substonce, LTSS, CCB, HH, DME, specialty, transportotion NEMT and non-medicol transportotion (os this affects sociol, nutritian, school meetings, work). The RCCO con olso provide support to clients in reoching gools outside of the health orena but those are secondory gools ond the RCCO should take those on in service to the member's overoll health and wellness.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

The absolute most importont piece of informotion is o patient's willingness to engoge ond portner to achieve o higher level of health. This can be ossessed thraugh metrics such as patient activotian, heolth confidence, heolth beliefs, individuol potient gools and borriers to thase gools and their sociol support network. Practical information on their heolth history is also importont but secondory to the patient's desire to chonge their heolth.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

This question is dependent on the individual client. Some clients hove little to no core coordinotion while others have core coordinotors from a number of different systems – RCCO, BHO, SEP, CCB, foster care, etc. Often clients don't recognize thot the folks they are working with are octually proviging core monogement services so when asked, they report that no one is monoging their care but with better infarmation we can determine thot they are in foct working with 2 or 3 core coordinotors in different systems. A shared dota system for eoch of these systems that are poid to coordinote care could facilitate better connectian points between individuol core coordinotors and eliminate the need for duplicotive or occasionolly conflicting activities. Within Colorado Access where we ore the RCCO, the BHO ond the SEP we hove implemented processes to identify shared clients ond develop o single coordinote care plan but that isn't possible in all regions.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

For the most part, care coordination provided by other systems is focused on o specific areo. For exomple, BHOs provide coordinotion for behoviorol heolth covered services and diognoses, but don't tend to take o broader approach. SEP cose managers focus on home heolth and long term core needs, not the larger holistic view the client may need.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

HCPF can provide the RCCOs with information about what other programs the client is eligible for as well as current touch points for other state and federally funded programs.

A thoughtful review of the contract expectations of the various entities that are paid to provide care management and/or care coordination needs to be undertaken. Adding the FBMME population into the RCCOs has created even more overlap with the SEPs. The potential for duplication or less effective care coordination between programs is high and this should be addressed. Expectations should be clearly set for RCCOs, SEPs, CCBs and other programs such as Health Communities around care coordination and what role each plays in an effective and efficient system.

d. What are the gaps in care coordination across the continuum of care?

The biggest gap is the lack of data sharing and overlapping program enrollment. Frequently it is only through interacting with the patient that we learn about their engagement with other systems. A more coordinated approach to data sharing could eliminate this time consuming and unsatisfying discovery process. The RCCO can be the central point for care coordination but that expectation and requirement needs to be shared with all the other programs so that data can be defined appropriately.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☒	☒	RCCOs are mandatory reporters but this is primarily a BHO care coordination function
Affordability (assistance with prescriptions or co-pays)	☐	☒	☒	To some degree but resources are limited
Daycare / childcare	☐	☒	☒	As it relates to health care activities, long term services should be addressed through TANF
Economic stability & employment	☐	☒	☒	RCCO can be a resource but this is not a primary function or goal
Education	☒	☐	☒	For children definitely, for adults not a core function
Environment	☐	☒	☐	Again not a core function, can partner and coordinate with CDPHE and other local public

				health agencies.
Food access / nutrition	☒	☐	☐	
Health literacy	☒	☐	☐	
Housing	☐	☒	☒	RCCO can provide a supportive role
Language or translation services	☒	☐	☒	
Literacy	☐	☒	☒	For children this is addressed through coordination with the school, for adults can provide referrals but shouldn't be a primary RCCO goal
Transportation	☒	☐	☒	As it relates to health care and overall health but not related to employment, recreation, etc.
Other	Whatever RCCO is expected to perform, need to ensure it is inside of appropriate legal parameters and that it is not the responsibility of some other system Where is the funding mandate for each of these requirements; is there a responsible party			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	**Coordinate care?** Yes	No	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☒	☐	
Certified Addiction Councilors	☒	☐	
Certified Nurse Midwives	☒	☐	
Community Health Workers	☒	☐	
Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☒	☐	

Licensed Mental Health Counselors	☒	☐	
Licensed Professional Counselor	☒	☐	
Masters of Public Health	☒	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	
Nurse Practitioners	☒	☐	
Patient Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☒	☐	
Psychiatrists	☒	☐	
Psychologists	☒	☐	
Registered Nurses	☒	☐	
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	
Other	Please type your response here.		

We believe that the credentials of the care coordinator are not of primary importance. We utilize a multi-disciplinary team as we recognize that the different skill sets in each of these areas are necessary to provide a comprehensive care management program. The most important skill for a care coordinator is the ability to connect with and motivate a client toward better health. With a multi-disciplinary team, the skills one care coordinator may lack can be made up for by other members of the team giving the member the benefit of all of these areas of expertise.

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	

Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

We believe care caardinotian in inherently on individuolized functian ond while members af o graup may have similor needs, eoch situatian is unique and should be addressed os such. Population heolth ond outreach strotegies con be opplied to same af the graups abave os opprapriote in a cammunity ar a region but requiring o program to deol with each individual graup takes owoy the RCCOs obility to determine what is needed in an oreo ond devote resources accordingly.

18) How do you envisian the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

One camplexity thot is unique in deoling with the faster core system is the requirement to get releases af infarmotion from social services in arder to effectively interoct with faster parents. Working with the foster parents is key to praviding effective care coordinatian but is impassible withaut this consent ond getting individualized cansents far the cose workers in a resaurce intensive and aften unsuccessful process. This issue tends to be handled differently between the RCCOs ond BHOs so clorificotian on expectatians and requirements ocross systems is needed. Far children with special needs autside af the foster core system, caardinotion with various ogencies con be useful when goad relotianships are established but cannectians shauldn't be mandated. Effective callabarotian and caardinatian anly hoppens when bath parties came to the table willingly ond nat oll agencies wont to be in thot role.

19) How should care coordination be evaluated? How should its outcomes be measured?

Care caordinotian metrics shauld include o measure whot is octuolly being pravided by the core coordinotors. The ultimote autcame af chonging patient behavior or supporting better access to, ond utilizotion af care

should be one of the things evoluoted but not the only thing. Other metrics could include potient engogement ond octivation, oppropriateness of core plons, core plon gools ochieved. Client sotisfoction should olso be on importont component os thot con drive the ultimote success of the relotionship. It should olso be understood thot core coordinotian is in most coses ond long term intervention ond so evoluotion ond meosurement should be done on o longitudinol bosis.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

    a. What is the PMPM cost for providing care coordination services?

Care coordinotian is o function thot con expand or contract depending on the functions expected and the funds ovoiloble.

    b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

No, vorying poyment by population odds o layer of complexity in terms of monaging the progrom and is difficult to accaunt for in varlaus practices ond community groups. The availoble funds for each region shauld be set and the RCCOs and PCMPs should be accountoble for allocoting the funding to each population as oppropriate.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

No, RCCOs shauld hove the flexibllity ta deploy resaurces os they need to in their community and take an innavotive care monogement programs and pratocals ta determine whot warks in different areas and with different papulations. Mandoted ratios can lead ta ineffective and inefficient resource allocotian that doesn't ultimotely achieve the gools af the progrom.

    a. Care coordinator to client ratios. If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐

3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

The Deportment should evaluate the care management is being delivered but the content ond structure of thot core management should be determined by the RCCO based on their region's needs. Eoch RCCO should hove their own core monogement evaluotion program ond the Deportment con determine how closely the RCCO is following their program ond model. More prescriptive evaluation models have the effect of limiting the creativity and flexibility the RCCOs need to work with their community partners and achieve the desired outcomes. More regimented program and processes keep resources tied up with low or no volue activities thot ore contractually required and thot weokens the overoll success of the program.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- *Doto reporting for PCMPs to RCCOs*
- *RCCO Contracting with PCMPs*
- *Oversight ond responsibility of PCMP/which RCCO do they 'belong' to or ore 'shored'*
- *Approoch to PHI with community portners (led by HCPF)*

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Bidders need to demonstrate history in o region, significont depth ond breodth of relotionships with stokeholders ond o commitment to serving this populotion over time. Bidders who ore in seorch of o profit of wont to use Medicoid os o spring boord to grow other membership should be scrutinized.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

We ocknowledge that it is chollenging for practices to work with different RCCOs ocross their practice. This con't be ovoided in some situations without significant baundary chonges (which are addressed elsewhere in this RFI). Howevер in situotions where a practice has the mojority of their members with ane RCCO ond only a small number with ane ar more ather RCCOs, the practice should be able to work with the RCCO thot hos the mojority of its members if this is feasible operationally for the Deportment and the RCCOs. It is aur experience that RCCOs are more than willing to work together to develop unique solutions to progroms so there ore likely other woys to oddress this issue thot could be explored.

In proctical terms there are some exomples thot wauld need to be oddressed if this ideo were to be seriously considered:

- *Could a PCMP choose a RCCO with wham they hove very little ar no membership?*
- *For large clinics systems, such os FQHCs, chaosing o RCCO from wham to supply and receive oll reporting is daoble but moving all clients associated with these large systems from several RCCOs to one RCCO will imbolonce the member distribution across RCCO regions which wos an eorly premise of the program.*
- *Haw would be choice be monoged? How long wauld be choice be for? Could ar wauld practices move between RCCOs? Would they have to choose for their entire papulation ar could different sub populotians be assigned to different RCCOs?*

27) Should the RCCO region maps change? Why or why not? If so, how?

RCCO and BHO region maps should be aligned to support population level prevention and care and to improve Triple Aim outcomes. Regions and service areas of SEPs, CCBs and public health systems need to be addressed as well.

28) Should the BHO region maps change? Why or why not? If so, how?

RCCO and BHO region maps should be aligned to support population level prevention and care and to improve Triple Aim outcomes. Regions and service areas of SEPs, CCBs and public health systems need to be addressed as well.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

There are many areas in which overlaps between contracts such as the RCCO and the SEP, RCCOs and Healthy Communities, RCCOs and BHOs, that the department could be well served by going through and integrating regulations and various policies to present a more streamlined approach to managing care across an integrated continuum for Medicaid recipients. The fragmented funding and contracts only creates the reality that we are all working with Medicaid clients (many times the same clients, doing the same things) with insufficient funding to fully support the work needed to do our contracts justice. In addition to this overarching review of rules and responsibilities and scope, below is a list of other areas in which changes should be evaluated

- *Payment reform – upper payment limit constraints*
- *Create hospital, specialist and member incentives*
    - *Example: When HCPF created hospital incentive to share data with RCCO, we immediately received more files than we had in three years of trying to get them on our own*
- *HIPAA and 42 CFR interpretations and data sharing requirements*
- *Less regulated/regimented oversight, encourage more creativity*
- *Better alignment with CHP+*
- *Evolve the attribution model and determine how to get new enrollees engaged in a medical home*

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

The substance abuse benefit should be at parity with the mental health benefit. The co-payments don't incent the right access to care behavior and need to be addressed. The adult dental benefit could be expanded. The diagnosis based BHO system continues to challenge the desired integration of care. Benefit

gaps exist for autism, developmental disability, and other traumatic brain injuries as well as appropriate long term care placement services for individuals with significant behavioral health disorders.

- Covered services verses covered diagnoses on BHO
- Alternative medicine options – evidence based solutions for things like pain management and cost containment
- Project ECHO – aligning evidence based practices with covered services and budget neutral

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

No, one of the most powerful components of the RCCO program is their unified focus and accountability for a population. There is no ability to "cherry pick" or complete for desirable members. The single RCCO in a region must establish relationships with all the providers in the region, understand all aspects of the health care system in that community and be a true driver of change and improvement in the entire system. If multiple RCCOs are in a region, focus will be on competing for members and differentiating between RCCOS and the community integrator focus will be lost. Multiple RCCOs per region would also impose a significant hardship on providers as they would need to choose which RCCO to contract with and risk losing members if they chose the other RCCO or work with multiple RCCOs for smaller patient populations which has already been identified by providers as an issue (see question 26). The current presence of the Denver Health Managed Care plan in Denver as well as the Region 5 RCCO provides some experience with having two programs in a region. Providers and members regularly and vehemently report confusion about both programs, providers are unclear on who to bill when, care is disrupted and another layer of complexity is added on to an already complex system.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

RCCOs should have an active role in attribution. The current claim based attribution model should be the first pass for attribution but other claim sources should be included such as BHO, CHP and exchange claims. As the PCMP network grows to allow for CMHCs and other non traditional primary care providers to function in this capacity, a new attribution model and methodology will need to be developed that recognizes those relationships. For members that don't have a strong connection to one provider, weak attribution information should be provided to the RCCOs and the practices who can examine other sources such as medical records or other program history to determine if a full attribution is warranted.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

The programs should coordinate on activities and have a general awareness of key priority areas and have regular meetings to share program information and establish key contacts in various areas for more detailed collaboration. Data sharing expectations should be laid out and available data should be incorporated into the SDAC.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

The programs should coordinate on activities and have a general awareness of key priority areas and have regular meetings to share program information and establish key contacts in various areas for more detailed collaboration. Efforts should also be directed to create complimentary but not duplicative services for people at DHS verses RCCO CM. Data sharing expectations between the entities should be described and any appropriate data should be included in the SDAC.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

The programs should coordinate on activities and have a general awareness of key priority areas and have regular meetings to share program information and establish key contacts in various areas for more detailed collaboration. This should include enrollment comparisons between programs so that duplicate enrollments can be identified and the clients managed by the appropriate program as well as collaboration on health insurance education and "churn" management.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

No real need for collaboration at this time but if needed, the entities should work together.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

The stakeholder group for the ACC is very broad and as the program grows, so do the number of people who have some connection to the program. The Department should re-evaluate the current committee structure and determine what committees are useful and valuable and which are not. Each committee needs to have a specific role and function and an understanding of how the Department wants to use their input. However, having a role on a formal committee should not be the only way to have a voice in the program. The Department should hold regular stakeholder meetings on a variety of topics throughout the state to consistently gather feedback and build connections between the different entities. The RCCOs should also continue to feed information to the Department on behalf of the stakeholders to inform program and policy directions.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

There are gaps in all of these groups in areas across the state. It is unreasonable to expect that there will ever be a network of all these various providers that will be adequate statewide. There will always be gaps and areas in which there are more providers than are needed. The question for the ACC program to focus on is how each RCCO addresses the gaps in their regions and works within their communities to develop and grow the networks over time.

a. If no, what are the gaps?

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

They must play a significant role. They are one of the largest expenses in the program and a huge focus in terms of re-aligning their services.

b. What role should pharmacies play in the next iteration of the ACC Program?

To the degree that they can support the goals of the ACC, they should be at the table but it should be an option to include them, not a requirement.

c. What role should specialists play in the next iteration of the ACC Program?

Specialists provide a vital service and are in very short supply in many cases. They need to be formally incorporated into the ACC and actively engaged in the transformation of the Medicaid program.

d. What role should home health play in the next iteration of the ACC Program?

To the degree that they can support the goals of the ACC, they should be at the table but it should be an option to include them, not a requirement.

e. What role should hospice care play in the next iteration of the ACC Program?

To the degree that they can support the goals of the ACC, they should be at the table but it should be an option to include them, not a requirement.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

The SEPs and CCBs need to be formally incorporated in the ACC. All three entities have responsibility for coordinating various aspects of care for the same clients and there are many opportunities for duplication of care coordination services or less effective care coordination. The contracts and contract expectations need to explicitly lay out the responsibilities of each entity as they relate to each other and clearly delineate how the entities need to work together.

g. What role should counties play in the next iteration of the ACC Program?

As a key area in which clients interact around their Medicaid benefits, counties must have a role in the ACC. Their responsibilities and accountabilities related to the ACC need to be laid out and consistently communicated and measured.

h. What role should local public health agencies play in the next iteration of the ACC Program?

As entities that are responsible for the health of a population that overlaps significantly with the RCCOs, the functions of each should be clearly understood and areas of collaboration and coordination laid out in contracts or MOUs.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

To the degree that they can support the goals of the ACC, they should be at the table but it should be an option to include them, not a requirement.

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at	☐

Primary Care Medical Provider Clinic	
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

If the Medicaid dental contract is being administered through an ASO contract, that contractor should be held accountable for ensuring an adequate network of providers and working with the RCCOs to coordinate dental care. The RCCO should be in a supporting role in terms of coordinating access to dental care and the contracts for both the RCCO and dental ASO should be extremely clear on what role each plays and ensure that there is no duplication of efforts. This is true for all state contracts in which a vendor is responsible for a certain service. The presence of the RCCOs and the ACC shouldn't remove any requirements for other contractors to perform their functions. Any contracts that include any responsibility for care coordination should be reviewed to ensure no duplication of requirements and clear delineation of roles and expectations about collaboration. A review of RCCO, BHO and SEP contracts highlights many areas in which opportunities for duplication and confusion about roles can occur.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

No, as lang as the PCMP model is "any willing provider" then thot should apply acrass all types of providers. The practice of hoving limited or preferred networks is challenging for potients to novigote and con create more confusion and frustrotian for the members ond the praviders.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☒	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☒
Provide clinical screening tools	☒	☐	☐	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☒	☐	☐	☐
Provide registries	☒	☐	☐	☐
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☒	☐	☐	☐
Supply behavioral health surveys	☒	☐	☐	☐
Supply other self-screening tools	☒	☐	☐	☐
Administer behavioral health surveys	☒	☐	☐	☐
Administer other self-screening tools	☒	☐	☐	☐
Prepare client action plans	☒	☐	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☒	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☒	☐	☐	☐
Provide standing pharmacy order templates	☒	☐	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☐
Provide directory of other resources	☒	☐	☐	☐
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others				

All of these con be provided by the RCCO assuming thot they are things thot practices want ond will use. There shouldn't be any requirement to provide any set list of these octivities. The RCCO needs to be free to develap the tools and supports thot the proctices in their region need ond not be tethered to a list of supports that won't be volued by the provider community.

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

RCCOs should do this only os it relotes to impraving KPIs and overoll program outcomes. Tronsformotion far the sake af transformation should be led by the practice ond supported by the RCCO as oppropriate.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

This should be purely an outcame driven decision. Achieving externol certificotion or accreditotion is af na value if it daesn't ultimately imprave the client experience and leod to high quolity core. Providers should be incented for incremental progress toword stondord goals, not just on achievement of a single stotistic. The Deportment ond the RCCOs should work together with practices to identify some process or interim metrics thot demanstrate a practice's wark to improve the client experience and reward progress along the woy.

57) Should the Department require that PCMPs utilize disease registries to manage the health af their population?

They should be required only ta the extent thot their use octuolly leads ta better outcames. The proctice af requiring specific tools thot dan't drive outcomes just ties up valuoble resources and keeps providers ond RCCOs fram developing new and creotive oppraaches to comman problems.

58) Please share any other advice or suggestians about pravider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

While we are moving to a more value based system, the most significant payment component is still fee for service. This payment model doesn't support the comprehensive transformation of the system that is being sought through the ACC. As long as providers are primarily paid via FFS, they will continue to focus on volume rather than outcomes and quality of care. The current model of providing a bonus for achieving outcomes isn't significant enough to drive change within a practice and the fact that it is paid on a regional level often serves to de-motivate smaller practices who see no way to move the regional average. In order to truly drive transformation, the payment model must change in as dramatic a fashion as the transformation that is being sought. In many cases, significant change will be driven by pain rather than rewards.

There are also many services and functions that are not currently covered or reimbursed such as provider to provider consultation, or health and behavior codes or more efficient means of provider patient communication like phone and email consults. Allowing for these important services to be provided and paid for acknowledges their value and generates data that can be studied for additional intervention opportunities.

The current process of having PCMP payments come from the Dept misses an opportunity to further connect the RCCOs and the providers. The RCCO and PCMP payment amounts are not sufficient to perform all of the contractual requirements and have funds remaining to drive transformation on a system level. The next iteration of the ACC could include a regional pool of funds that can be used collectively to incent change or support community level services. This could also be a mechanism of distributing shared savings in a less complicated fashion.

The current ACC program and payment models don't include any mechanisms to formally engage clients in the cost of their care. This is an area that could be explored in the next iteration of the ACC so that members "have some skin in the game" and are incented to learn more about their insurance and become more active and engaged consumers.

The current ACC payment model also excludes major players in the health care system such as hospitals and specialists and they need to be actively engaged in the program's funding structure.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Some do and some don't. The skill level and infrastructure of PCMPs across the state is very broad and varies from being extremely sophisticated and innovative to being very limited and antiquated. There is no one size

fits all approoch to providers. In addition, the current model of paying incentive dollors based on regionol improvement demotivotes smoller proctices os they feel os though they con hove no impoct on the regionol outcomes. The current model is olso o block or white model in which you either ochieve or foil, there is no recognition of continued progress toword o gool or incentives to tockle long term tronsformotion octivities. Providers ond RCCOs need opportunities to demonstrote smoll successes ond steps toword ochieving these importont but hord to reoch gools.

It should olso be broodly recognlzed ond understood thot most metrics ore ultimotely dependent on potient behoviors ond there is currently no opportunity for providers to be evoluoted on the work they ore doing and hove direct control over. It is widely ocknowledged thot the incentives for the potients ore not olwoys oligned with using core oppropriotely, for exomple hoving o primory core visit co poy but no co poyments for emergency room visits or ombulonce services. Providers ond RCCOs con provide the highest quolity medical homes and coordinote core but ultimotely the outcomes meosured lie with the potient. Monitoring ond evoluotion of metrlcs thot directly meosure the providers ond RCCOs octivities in oddition to ultimote potient driven outcomes ollow for progress to be meosured in both orenos ond will provide more incentives for positive chonge.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

We ore currently licensed by the DOI os on HMO ond risk beoring entity.

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

The RCCOs should distribute the poyments to providers to reinforce the connection between the RCCO ond the provider ond ollow the RCCO to better monitor ond support o proctice's progress.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

The limitotions ond requirements of CMS ond Medicoid regulotions need to be more tronsporent ond well understood by the RCCOs ond other ployers in the ACC progrom. The collective creotivity of o lorge group of people working with oll the relevont informotion con be very powerful ond when focused on o chollenge such os poyment reform within the current regulotory infrostructure con bring new ideos os well as provide odditionol support to push for federol regulotory ond progrommotic chonge.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of *core, sotisfoction of clients ond providers, ond heolth outcomes?*

- *CAHPS like questionnoire from HCPF to clients thot ollows for specific meosurement of eoch portion of the heolth core system (benefits, PCMP, RCCO, LTSS, tronsportotion)*
- *Leveroging olreody existing occreditotions such os NCQA certificotion, CPCI ond meoningful use to tie together PCMP efforts with progrom performonce ond incentive reimbursement*
- *Access to core stondords – how well providers support member's desire to utilize services*

- *Metrics incarparating member feedback about experience – not just CAHPS but real time satisfactian infarmatian and provider level sampling*
- *Activities that influence ar drive access ta specialty care*
- *Mare in depth analysis af experience and autcames inside af each measure because high level KPIs are nat demanstrating success; need ta dig Inta the details behind those ta see what is and isn't warking*
- *Payment that aligns the entire neighbarhaad ta participate in meaningful way, includes all players in a neighbarhaad*

66) Measuring Client experience. Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should It be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	
SF-12 Health Survey	☒	☐	
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☒	☐	
Focus groups	☒	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

If appropriate claims metrics can be identified they should be used but if no metrics are available, work with the RCCOs to evaluate their population health programs individually.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

Quality and performance metrics should be transparent and replicable and should consider both improvements, maintenance of improvements and incremental steps toward improvements. Metrics and evaluation should be approached as a collaborative process that provides opportunities for learning and ongoing change. Metrics should not be approached as a pass fail and RCCOs and PCMPs should be given the opportunity to narrate metrics to highlight activities that were undertaken to improve each measure, whether or not they were successful. RCCOs and PCMPs should be evaluated both on their ultimate outcomes but also on their quality improvement process and ability to learn from their activities.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐

31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☒
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

KPIs should be consistent ocross RCCOs and providers but the baselines and levels of improvements should be regionally based. KPIs ond other metrics should be consistent and aligned with other stotewide models such os SIM ond CPCI to allow for maximum focus on a few metrics.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Based an improvement os well os maintain improvement. Constant ond consistent improvement isn't always possible or practicol. RCCOs ond providers should be rewarded for making significont improvements ond maintaining those improvements over time while making significant progress on anather metric. Process or interim steps should alsa be included and rewarded at a lower level to incent ond encourage innovation ond pragress even when the ultimote goals oren't met.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

No, measures should be develaped to evoluate the chonges that are desired and colculoted ot the frequency with which they are expected to change. There oren't ony hord ond fast rules, eoch metric should be Individuolly development ond monitared.

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☒
Other	☒

If you checked the "Other" box, please describe payment frequency below:

Bi- annually, unless metrics truly change more quickly

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

RCCOs and other entities will develop whatever programs and services that are needed that can be supported with the funds provided. Since the RCCO program hasn't been static and the requirements and expectations are constantly growing, it is a function of determining what programs and services will best support each community and region and result in the desired outcomes while living within the available budget.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☒	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☒	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☒	☐
Shared decision-making tools	☐	☐
Telemedicine software	☒	☐
Other:	☐	☐
Other:	☐	☐

79) Importance of technology by type. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☒	☐
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☒	☐
Practice assessment tools	☐	☐	☒	☐	☐
Health risk assessment software	☐	☐	☒	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☒	☐	☐
Patient education wellness tools	☐	☐	☒	☐	☐
Provider/case manager directory	☐	☐	☐	☒	☐
Shared decision-making tools	☐	☐	☒	☐	☐
Telemedicine	☐	☐	☐	☒	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Primary care practices consistently ask for data about their entire patient population, not just a subset of their patients. Including all Medicaid data (ACC and non ACC) and other claim data that is available such as CHP, exchange and other information would allow providers to use the HIT as a standard part of their practice. Integration of EHR or EMR data into more coordinated and functional tools would also allow providers and RCCOs to see connections or gaps in care more easily.

81) How can Health Information Technology support Behavioral Health Integration?

Integrated medical records that contain medical and behavioral health information would help both systems provide improved and better integrated care. Additionally, HIT could support access to more timely data so that systems and providers can more promptly respond to diagnostic/clinical/claims trends. However the issues of what behavioral health information can or cannot be shared needs to be resolved in a statewide fashion and that determination broadly disseminated before any HIT solution can be developed.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

It would be good to hove better insight into the metrics ond calculations within the SDAC so metrics could more easily replicated. The current propriety noture of some of the SDAC metrics is extremely challenging to understand and that creotes problems with buy in to the model. Doto thot is used to evoluote the RCCOs or the PCMPs should be completely tronsporent and replicable and providers ond RCCOs should hove direct input into the metric design.

In terms of a shared dota ond onalytic resource different from the SDAC, the current RCCOs hove each developed their own mechonisms to analyze the doto which would be difficult to merge into one appraoch. The unique needs of eoch regian and their portners and stakeholders can best be addressed by pravlding the RCCOs with os much row data as passible and continuing to develap the SDAC to be a more useful provider focing tool.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

It seems the time to implement o shored core monogement tool has possed. At this point, each RCCO hos invested in their own tools and systems, mony BHOs hove done the some and individuol provider groups are bringing up their own systems os well. In addition, the SEPs hove a separote tool, Healthy Communities have o seporate system, etc. Merging them into one system now would be too complicated and likely toke everyone bock several steps. Some work could be done to coordinote documentation/trocking requirements so that information con more easily be shared between systems if ony of the groups decide to go thot route.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

Finding a single tool that will meet the needs and demonds of multi different groups is unlikely. RCCOs should work within their regions to determine what tools already exist, whot moy be needed ond determine how best to deploy any tools and/or infarmotion.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

The moin criticism of oll provider directories is how quickly they become out of dote. A useful Medicaid provider directory would need to include current infarmation on providers who ore accepting new potients, not just providers who hove ever accepted a Medicaid client. It would also be helpful to have informotion about the provider's longuoge and specialized services or programs directed at certain populations. Information an panel size ond/or % of practice dedicated to Medicoid would also be very helpful.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

If the systems can provide real time or neor reol time access to hospitol and emergency room dato to RCCOs ond PCMPs as well as provide access to better coordinate a potients core, they should be integrated. Hawever if the systems aren't able to deliver that informotion in o timely and efficient foshion then their involvement moy be more of a distroction than o value add.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 075

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Kathleen Joy

Location: Western Colorado Pediatrics Grand Junction Colorado

Mesa County

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Western Colorado Pediatrics Associates

Location: Grand Junction Colorado

☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty:
  ii. Area of practice: Pediatrics
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

No

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Multiple families are on Medicaid, but services are often limited and/or not paid for.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☒ Likely
☐ Reserved (waiting to see the RFP)

☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

Please feel welcome to describe why or why not using the space below.

If you answered "yes" above, how long?

☐ Less than one year
☒ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.
- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.
- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.
- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:
    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.

- If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.
- So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
- Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
- There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing SDAC data is just one way to understand the activities within a medical home. SDAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:

a. Assistance with finding a behavioral health provider for patients
b. Telephone consultation by a child psychiatrist to primary care providers
We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Core Coordinotion

Question 12) What needs for children/families should be coordinated in medical homes ond are there services thot should not be a port of care coordinatian by the pediotric ond family medicol home

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Our medical home relates to multiple RCCOs and we want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we could receive a pmpm from all of them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where should care coordination be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill? The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County
- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high

performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

- Since children are the majority and give the best chance of truly improving health and wellness, KPIs need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

<u>There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully.</u> Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and provider from medical homes to develop a vetting process that will enable HCPF and RCCOs to trust medical home self-reported real-time data.

- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd. Appropriate child health measures could be selected from the following measures :
    - Well child visits appropriate for age
    - Developmental screening by three years of age
    - Teen depression screening
    - Complete immunization status by age two
    - Post-partum depression screening rate for mothers of newborns by age 4 months
    - Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
    - Patient (or family) satisfaction ratings
    - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 076

Accepted by: KJDW

Notes: Standard cover sheet added; additional email response integrated

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

Response From:

DCCCA, Inc.
3312 Clinton Parkway
Lawrence, KS 66049
785841-4138 ext 147
cpederson@dccca.org

ACC Request for Information

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: DCCCA, Inc.
Location: Lawrence, Douglas, Kansas

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: DCCCA, Inc.
Location: Lawrence, Douglas, Kansas
X Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
X Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
X Other (please describe): privatized provider

Are you currently involved in the ACC program?

☐ Yes
X No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
We have worked with Value Options in Kansas

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
We provide Medicaid paid behavioral health and child welfare services

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
X Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

2) What is not working well in the ACC Program?

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

DCCCA has extensive experience providing child welfare services to families using outcomes-based performance measures as well as pay for performance in the Kansas system. Our experience has been that when outcomes are clear, owned by all stakeholders and measured and reported frequently the system responds well and families benefit. All groups involved in services to families must have a clear understanding of how the outcomes are measured and how they are based on clear and achievable standards in the industry. Competition between providers/vendors that rewards the achievement toward outcomes works to provide quality services to families and individuals. The goals and measures may need to be adjusted over time so that quality vendors can achieve reasonable outcomes without going bankrupt during the initial years of implementation.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	Should provide exceptions for very high cost individuals
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	Reasonable caseloads should be established in the contract and measured.
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	Common training resources and opportunities should be shared across providers.

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Others	Please type your response here.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

For care coordination you might consider adapting the Family Group Decision Making model used in social services. It is a process in which a person who needs help is assisted with arranging a facilitator-led meeting with family and significant others to inform them of the situation and volunteer to provide specific assistance. This could be taking a high risk patient to appointments, checking blood pressure or medications daily or ensuring their environment remains safe. In social services the cost for preparing for the meeting and facilitating with some follow-up is about $2000. There are evidence-based models for Family Group Decision Making and the Kempe Center at CU specializes in this approach.

b. How should RCCOs prioritize who receives care coordination first?

c. How should RCCOs identify clients and families who need care coordination?

Chronic users of the system, serious or relapsing conditions, multiple family members with high need.

Use data collected in the system to establish cut-off points for who qualifies with exceptions considered

And approved by designated individuals within a very short time period.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

Require specific encounter data documenting care coordination by client/family

12) What services should be coordinated and are there services that should not be a part of care coordination?

Services should be provided based on assessed and documented family need. Consider using the evidence-based North Carolina Family Assessment Scale (NCFAS) which is free in the public domain, easy to document and quick. It can also be used post intervention to measure family change.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

Need assessed by a measurable instrument; history of providers they have used in the past, who else in their household has the same or similar condition or need

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	X	☐	X	Tracking client outcomes data by provider to determine who continues to be an approved provider e.g. % of children free from abuse and neglect using a consistent definition
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	X	☐	X	Ensuring families have assistance accessing care if it is a barrier to achieving outcomes
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	Early childhood education and high quality pre-school definitely support better long-term outcomes for individuals.
Environment	☐	☐	☐	#1 Children need to be safe
Food access / nutrition	X	☐	X	Ensuring families have access to proper nutrition if it is a documented unmet need
Health literacy	☐	☐	☐	Health literacy is helpful for families but not as important as food, housing, child care, employment and safety.
Housing	☐	☐	☐	Safe and stable housing for families with children
Language or translation services	X	☐	☐	We find that family members can often provide reliable translation at no cost but some funds are necessary for exceptions
Literacy	☐	☐	☐	This is not generally a barrier to services
Transportation	☐	☐	☐	Provide needy clients with bus passes

Other	Transportation to appointments is a huge barrier. No show rates are very high. As many services as possible should be provided in-home such as assessment, case coordination and some service delivery.

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	X	
Certified Addiction Councilors	X	☐	We tried in-home drug counseling that did not work well.
Certified Nurse Midwives	☐	☐	
Community Health Workers	X	☐	
Generalists (BA/BS/MA/MS)	X	☐	Only if well trained on safety and service delivery
Health Coaches	☐	☐	
Licensed Clinical Social Workers	X	☐	This is an expensive option for in-home but a good choice for assessment and case planning
Licensed Marriage and Family Therapist	X	☐	Same as above
Licensed Mental Health Counselors	X	☐	Same as above
Licensed Professional Counselor	X	☐	Same as above
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	Perhaps to sign off or supervise some case plans
Patient Navigators	☐	☐	

Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	X	☐	
Registered Nurses	☐	☐	
Social Workers	X	☐	Excellent for in-home assessment and service delivery
Wraparound facilitators	☐	☐	
Other			

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 077

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Kelley Vivian
Location: Colorado Springs, El Paso County, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Community Health Partnership
Location: Colorado Springs, El Paso County, Colorado

☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. **Type or specialty:** Click here to enter text.
  ii. **Area of practice:** Click here to enter text.
☐ Provider advocate (e.g. medical society)
☒ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ **Other (please describe):** Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Community Health Partnership (CHP) is the RCCO for Region 7.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Click here to enter text.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

☒ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

Allowing RCCOs to be implemented in response to the unique nature of each community is working well in the ACC program. Also, the inclusion of RCCO Leadership Group and RCCO staff in HCPF meetings and discussions about ACC program implementation is also working well.

2) What is not working well in the ACC Program?

3) What is working best in the Behavioral Health Organization (BHO) system right now?

The State of Colorado has been a strong leader and model for the nation over the past 20 years as it relates to the management and delivery of Behavioral Health services. Instead of operating in a system that emphasizes volume through a fee for service system, Colorado has been progressive in their approach by moving to a capitated, risk-based approach for an entire population of people. Risk stratification, expansive access, management of expensive clinical care with best practice clinical pathways and a strong emphasis on taking care back into the communities has allowed for significant statewide savings and better care outcomes. With over 20 years of experience in this risk-based model, which is a fundamental component in any payment reform initiative, the BHOs have figured out how to manage provider risk. This skill set can be scaled to accomplish similar outcomes across all of healthcare.

4) What is not working well in the BHO system?

Even though the BHOs have operated in a managed, risk-based contract for decades, over the years this model has continued to emphasize encounters and retroactive fee for service accounting continues to take place. To be successful in healthcare delivery moving forward, HCPF will need to plan for a system that reimburses strong, performance-based outcomes.

5) What is working well with RCCO and BHO collaboration right now?

RCCO and BHO collaboration is working well at the community level with great cooperation between the RCCO and community mental health center (CMHC) system. RCCOs and CMHCs are working together to support whole-person care coordination and integration of behavioral health and physical health into primary care and CMHCs.

6) What is not working well with RCCO and BHO collaboration right now?

Differences in interpretations of HIPAA among BHOs and RCCOs is hindering the ability to share population data and achieve better health outcomes, reduce costs, and treat each client holistically.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

First, as alignment continues between the RCCO and BHOs, the RCCO RFP should continue to emphasize further integration of programs, data and finances to meet goals related to the development of health homes and person-centered care, as well as finding further efficiencies. RCCOs that can demonstrate continued movement in this direction should be rewarded with higher scores on RFP scoring.

Second, the Colorado State Health Innovation Plan is critical to the advancement of healthcare integration in Colorado. Bringing together stakeholders from multiple disciplines to create a centralized platform to best deliver care and track both the data and finance on the back end is critical. Feedback from the medical community, behavioral health community, social services, and educational fields need to be included.

Third, to truly allow behavioral health to integrate into physical health, the alignment of government funding streams must occur. Funds from HCPF (Medicaid) and OBH must work in tandem to allow for comprehensive care of patients as well as achieve population health goals moving forward.

Fourth, to provide comprehensive care, we must continue to move away from a fee for service system, which emphasizes volume, and move towards a risk-based payment model where comprehensive care utilizing advanced techniques such as risk stratification, produces stronger clinical and financial outcomes.

Fifth, as we move further into integrated care planning for people with multiple, complex health needs (i.e., intellectual and developmental disabilities, organic-based dementia care and traumatic brain injuries), we encourage HCPF to utilize BHO/MSO experience since they have been successfully providing risk-based population care for years.

Sixth, creating enough flexibility in the billing and reporting systems to distill specific types of encounters in organizations that are hosting behavioral healthcare providers but not hiring those providers directly.

Lastly, we encourage HCPF to consider enhancing the existing Medicaid SUD benefit to a full continuum of care, including services in parity with those offered for mental health and physical health (such as intensive outpatient, partial-hospitalization and inpatient / residential treatment services) to produce better health outcomes and lower costs over time.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	Barrier? No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☒	
Community Behavioral Health Services Rule	☐	☒	
Covered diagnoses list	☒	☐	If there was not a limited diagnosis set, it would allow for much more comprehensive services to be provided to patients in a physical health setting.
Different behavioral / physical health reimbursement	☐	☒	Right now we cannot bill physical health in the behavioral health setting so CMHC are not able to run primary care unless they become an FQHC. Also physical health is incentivized by FFS and CMHCs are not, so the billing mechanisms do not align.
Institutions for Mental Diseases exclusion	☒	☐	IMD continues to be a barrier for expanded services to meet local population needs. While the 1915 (b) waiver through the Medicaid Managed Care program offers some flexibility, the risk of how our waiver could be interpreted by the Feds have prevented many service expansions from occurring in our community.
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	Better alignment in licensing and compliance standards between OBH, HCPF and CDPHE could assist with streamlined standards and service provision process for approach by state agencies
PCMP financing structure	☐	☒	
Per-member per-month amount	☒	☐	The PMPM paid to PCMPs is insufficient to move toward patient-centered medical home care that is inclusive of behavioral health providers as a part of the care team.
Physical space constraints	☒	☐	Locally we are looking for additional solutions for expanded space for primary care in the CMHC (bidirectional care). As 2703 health homes continue to be considered in Colorado, this will remain an important area to address.

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Privacy Laws (HIPAA, 42 CFR)	☒	☐	42 CFR is a real problem for care coordination and a barrier to ensuring the best care is delivered to patients; HIPAA is less of a concern
Professional / cultural divisions	☒	☐	As the primary care and behavioral health fields continue to come together and integrate, professional and cultural divisions is something we will need to continue to bridge. The BHO and the MHCs have very rich experience in this area that can be utilized to bring the two fields closer together.
RCCO or BHO contracts	☐	☒	
Staff capacity	☒	☐	Work force issues and staff capacity is an issue nationally for all of healthcare. We have an aggressive state and local recruiting strategy to bring in specialists in the behavioral health area.
State/Federal rules or reporting requirements	☒	☐	The reporting requirements need to be aligned across state agencies
Technical resources / data sharing	☒	☐	For best continuity of care, SDAC data needs to be shared with the BHOs and encounter data from the BHO needs to be shared with RCCOs
Training	☒	☐	While there are national training programs to best train BH specialists to work in Primary Care, the field is still fairly young. Training happens mostly through internship programs and certificate training programs. Very few Masters/Doctorate programs teach to integrated care and even fewer primary care residencies and nursing programs train to how to utilize behavioral health consultants as a part of the medical team. More work needs to continue in this area.
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

We are strong advocates of the SAMHSA 6 levels of integration. This approach aligns with an emerging national standardization of levels of behavioral/physical health integration. It allows for training, research and cross-collaboration while using a similar language and operational approach.

http://www.integration.samhsa.gov/integrated-care models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf

10) Please share any other general advice or suggestions you may have about behavioral health integration.

We strongly believe that in order to achieve full integration across primary care practices and behavioral health, the principles of integration need to be agreed to across state agencies and should align across all payers. Only through this alignment will the RCCO, BHO and commercial payers be able to accomplish the goals of Colorado's State Health Innovation Plan. This not only should align services and the integration model (e.g. SAMHSA 6 Levels of Integration Model), but also administrative systems, data, financing, provider needs, and patient needs including social determinants of health, physical and behavioral health needs. Additionally, there are many key populations that still rest in different oversight and funding streams that need to be integrated into our centralized care structure: such as people with autism-spectrum disorders, traumatic brain injuries, and developmental disabilities.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

Care coordination are "activities that address the health and wellbeing of the whole person, including physical health, behavioral health, and social and community supports such as educational, financial, transportation, and personal safety. Care coordination should include a multi-disciplinary team-based approach that involves the member and member's family in shared decision making to create a care plan that helps the member achieve desired health outcomes".

b. How should RCCOs prioritize who receives care coordination first?

RCCOs should be allowed to prioritize members for care coordination according to their own methodology, which should reflect the needs of the community served. RCCO should also have the ability to support members that self-identify for care coordination, members that PCMPs identify for care coordination, and members that other community agencies identify as being in need of support.

c. How should RCCOs identify clients and families who need care coordination?

RCCOs should use multiple sources of data to identify members, including SDAC, electronic health records, and community-based communication and referral systems. RCCOs that utilize local systems of communication and data sharing should be awarded additional points in the RFP scoring.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

RCCOs should document care coordination at delegated providers in ways that makes the most sense for the provider and promote tracking of care coordination across payers. RCCOs need to be respectful of the ability of each practice to document care coordination in its EHR and should support the costs of modifying EHRs to support care coordination documentation. RCCOs should document the provider's ability to conduct care coordination and track that ability over time.

12) What services should be coordinated and are there services that should not be a part of care coordination?

Medical, behavioral and home and community-based services should be coordinated and communicated across the care team, including to the client and to the client's providers. Social and community based services that support the whole person should be included in coordination to the extent possible; however, these services are difficult to document, often have extensive waitlists (e.g., housing), and require a client to be engaged and activated in order to achieve maximum success.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

RCCOs need real time access to client data, not data that is three to six month old, in order to support care coordination. Bidders should be awarded extra points if they bring other real-time data sources to the contract. These sources could include care management data, community-based health information exchange, hospital data, or other community-based data.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

RCCOs should be a part of their community so that RCCOs have knowledge of what other systems of care coordination exist. RCCOs should develop relationships with other care coordination entities so that RCCOs and other agencies can work together to serve the client. Clients should have choices in who leads their care coordination and RCCOs and other systems should honor that choice to the extent possible.

d. What are the gaps in care coordination across the continuum of care?

Social service needs such as housing and transportation present large gaps in the continuum of care. The Department should consider strategies for RCCOs to use their funding to help address these issues in their community. Bidders that demonstrate partnerships that support gaps in the continuum of care should be awarded additional points.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	**Should the RCCO have a role?** Yes	No	**Should the RCCOs coordinate with community supports and services?** Yes	**Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?**
Abuse, neglect, and trauma	☒	☐	☒	
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	

Daycare / childcare	☐	☒	☒	
Economic stability & employment	☐	☒	☒	
Education	☐	☒	☒	
Environment	☐	☒	☒	
Food access / nutrition	☒	☐	☒	
Health literacy	☒	☐	☒	
Housing	☒	☐	☒	
Language or translation services	☒	☐	☒	
Literacy	☐	☒	☒	
Transportation	☒	☐	☒	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved. RCCO should have a role in helping the client identify and access non-medical needs that support overall health. RCCOs can connect clients to services that exist in the community. Bidders should be able to demonstrate that they have an understanding of the impact of the social determinants of health on client's lives, how to connect clients to resources, and how to form partnerships in the community that support whole person health.			

16) **Requirements about who should** be **doing care coordination**. Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	
Certified Addiction Councilors	☐	☒	
Certified Nurse Midwives	☐	☒	
Community Health Workers	☒	☐	
Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☐	☒	
Licensed Mental Health Counselors	☐	☒	
Licensed Professional Counselor	☐	☒	
Masters of Public Health	☐	☒	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☒	
Nurse Practitioners	☐	☒	
Patient Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☒	☐	
Psychiatrists	☐	☒	
Psychologists	☐	☒	
Registered Nurses	☒	☐	
Social Workers	☒	☐	
Wraparound facilitators	☐	☐	
Other	Please type your response here. The Department should focus care coordination on the knowledge, skills and abilities of individuals rather than on licensure and post-secondary education. In general physicians, nurse practitioners and licensed behavioral health providers are in short supply in Medicaid and they need to be working to the top of their licensure to treat clients. Care		

coordinators of all background that have received cultural competency, patient navigation, and other forms of training that support client interaction should be care coordinators. RCCOs should build systems of care coordination based on the strengths and resources that exist in their communities, not solely on the licensure of individuals.

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☒	
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☐	☒	
Children involved in the foster care system	☐	☒	
Children with a chronic illness	☐	☒	
Children with a serious emotional disturbance	☐	☒	
Children with medical complexity	☐	☒	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☒	
Transition-age adolescents	☐	☒	
Parents and families	☐	☒	
Pregnant women	☐	☒	
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☐	☒	
Adults with a chronic illness	☐	☒	
Adults with a behavioral health diagnosis or substance use disorder	☐	☒	
Clients involved in the criminal justice system	☐	☒	
Clients with a disability	☐	☒	
Clients in a nursing facility	☐	☒	
Elderly clients	☐	☒	
Frail elderly clients	☐	☒	
Clients in palliative care	☐	☒	
Other populations, please comment: The state should endorse a standard definition of care coordination and require that potential bidders show how they would meet the tenets of care coordination in the contract. Bidders should be able to demonstrate that a sub-population may have			

unique considerations for care coordination and how its model of care coordination or relationships with other community agencies allows the bidder to serve the needs of individuals and of sub-populations.

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

RCCOs should be partners with child-serving agencies and bring medical resources to the table to support the child and family. The client, guardian or family should be able to select which agency coordinates care. RCCOs can also serve to support the child-serving agencies case worker with care coordination resources.

19) How should care coordination be evaluated? How should its outcomes be measured?

5ee #22 for more information.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

The true cost for providing care coordination is dependent on the intensity of the coordination and the number of people to be served. The current PMPM is inadequate to cover the cost of care coordination for the entire population to be served.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

PMPM could be risk adjusted by acuity, but this should not be attempted by population as every population has different care coordination needs and one-size-fits-all payment methodology may not adequately cover needed services.

21) 5hould there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

No. Care coordination should be client-centered and based on available infrastructure and capacity on the community. Unfortunately one cannot reach everyone in this population, due to their nature and economic situations.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐

101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

Since outcomes will be client specific, cost reduction and utilization of services may be the logical route in the short term. Client satisfaction measures specific to care coordination should be included. Long term evaluation will need to utilize outcomes measures that assess wellbeing and quality of life of the client.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

While it is important to establish criteria for eligibility for care coordination at the RCCO and provider practice levels, the need for and type of care coordination should be specific to each individual client. It must be person-centered to be successful, and we must recognize the need for flexibility to fully address the needs of our clients.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

CHP recommends that HCPF continue to allow RCCOs to implement the tenets of the ACC program in response to the needs of the community and providers. While the Denver market has overlapping RCCOs and a larger population that seeks care across RCCO boundaries, this issue is less present outside Denver.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

A bidder should be able to demonstrate a history of community partnerships that have produced results. A bidder should be able to detail partnerships, scope of work of each partner, and tangible outcomes from the partnerships. A bidder should have a presence in the community it serves and be able to describe its presence as more than an address or satellite office. Letters of support from community agencies, such as nonprofit social service agencies, county agencies, and other non-medical entities that serve Medicaid clients should be required in the bid package.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This would be confusing for clients and difficult for RCCOs to manage. If a client in enrolled in the RCCO outside his community, it would be difficult to choose a new provider when the client wishes to change providers. If a client lives in Boulder, sees a PCMP in Denver, is then enrolled into a Denver-based RCCO at the request of the PCMP, the client gets discharged from the PCMP or wishes to find a new PCMP, the Denver-based RCCO can only offer other Denver-based alternatives. Further, if the same Boulder client needs community resources and calls his RCCO, but the RCCO is Denver-based, it will not be able to help the client locate resources within the client's community. RCCOs form relationships with PCMPs, specialists, and community agencies inside their geographies. The current system of allowing clients to access care across boundaries supports client choice. Letting PCMPs choose to enroll their clients in a RCCO of the PCMPs choosing negates that choice.

27) Should the RCCO region maps change? Why or why not? If so, how?

CHP recommends keeping the current RCCO regions and the current ratio of one RCCO per region consistent in the next bid. Maintaining consistency and the ability to build upon hard won relationships outweighs the possible benefits of tweaking boundaries or increasing or decreasing the number of RCCOs.

28) Should the BHO region maps change? Why or why not? If so, how?

CHP recommends increasing the number of BHO regions and aligning the BHO regions with the RCCO region map to promote continuity of care for clients, improve partnerships among physical health and behavioral health providers, and streamline access to care for clients.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

HCPF should provide six months of transition time from the date successful bidders are announced to the implementation date. This would allow adequate time for contract negotiations, readiness reviews, and at least 60 days for transition teams to work together to ensure seamless transition of RCCOs for clients and providers. During the transition time, RCCOs should renew or execute contracts with PCMPs and other network providers, participate in a readiness review with HCPF, standup the customer service center, create transition materials for clients, and be ready to go live on the implementation date.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

CHP has the following recommendations for HCPF:

- **Extend continuous eligibility to adults in Medicaid.**

- **Remove payment barriers that impede behavioral health and physical health integration.**

As noted in HCPF's SIM proposal, Medicaid administers and pays for behavioral health benefits separately from physical health benefits, creating disparate delivery and payment systems. Medicaid reimburses behavioral health services through a fully capitated behavioral health carve out through the Colorado Community Mental Health Services Program. Despite the financial savings of this model, the carve out makes it difficult to integrate behavioral health services into the RCCO delivery system. **CHP recommends that HCPF modify billing rules regarding covered diagnosis, timing of behavioral health and physical health encounters, and allowable billable behavioral health services provided in a primary care medical provider (PCMP) office to incentivize integration.**

- **Allow RCCOs to distribute PCMP PMPM, incentive and shared savings payments**

As RCCOs work to develop relationships with PCMPs to drive care delivery system transformation, having closer involvement of the RCCOs in capitated and pay for performance payment delivery is a critical measure to encourage PCMPS to work with their RCCO partners. Having PMPM payments run through RCCOs will help PCMPs acknowledge the role of the RCCO in supporting members with care coordination and PCMPs with practice support.

Allowing RCCOS to determine how pay for performance and shared savings payments are distributed to providers in the RCCO will allow more leverage in driving service delivery transformation and building the medical neighborhood. For example, RCCOs can pass through incentives to PCMPs based on individual performance. RCCOs can also reward non-PCMPs for their role in meeting performance indicators and shared savings.

- **Enact payment reforms that target regional performance and allow regional shared savings**

CHP supports HCPF's desire to implement payment reform pilots and shared savings. Properly structured, alternative payment methods can promote high-value services and quality patient outcomes while reducing

costs in the ACC program. Regional variations in provider structure and community supports are best served by regional pools for shared savings and region specific payment reform pilots.

- **Seek solutions to remove restrictions around payment reforms for hospital services.**

Federal upper payment limit and hospital provider fee rules are disincentives to including hospital services in payment reform and risk sharing arrangements. Hospital services are a significant portion of Medicaid costs, and CHP advocates including hospitals in payment reform initiatives. To effectively implement payment reform and transition the ACC program to risk, HCPF must seek federal demonstration waivers or find other solutions to preserve federal funding and allow for payment arrangements beyond fee-for-service.

- **Provide claims data by provider location and at the Medicaid provider ID level.**

Prior to the next RFP, HCPF should require that all Medicaid providers obtain Medicaid IDs by location. For example, some RCCO providers have as many as 10 locations under one billing ID. This makes it impossible to determine what location within the ID would be best suited for certain practice transformation activities. Since RCCOs cannot isolate data by location for large providers it is difficult to determine care delivery system issues with accuracy—which then makes it overly difficult to determine how and which practice transformation activities need to occur to improve care delivery. Beyond location ID, being able to identify claims by National Provider Identification (NPI), will help drive better practice support initiatives.

- **Provide RCCO access to HCPF databases that collect information on Medicaid members, including systems used by Single Entry Points (SEP) and Community-Centered Boards (CCB) and Office of Behavioral Health.**

The foundation for care management is current data sharing and analytics at the point of service and assessing that information to make decisions about resources allocation. Initial care management cannot be better than the limited data presented at any given time. In order to fully achieve care coordination within the RCCO, RCCO's need access to data about the care our members receive from community-based services and behavioral health services. Requiring RCCOs to collect this information piecemeal and only from willing partners undermines activities to integrate systems.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

The current benefit structure does not support efforts by RCCOs and PCMPs to activate and engage patients in their healthcare. CHP recommends HCPF alter the benefit structure to include a higher co-pay for emergency department usage and a lower co-pay for primary care usage.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

CHP recommends keeping the current RCCO regions and the current ratio of one RCCO per region consistent in the next bid. Maintaining consistency and the ability to build upon hard won relationships outweighs the possible benefits of tweaking boundaries or increasing or decreasing the number of RCCOs.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

CHP recommends HCPF allow RCCOs to directly assist members with changing PCMP attribution. The primary tenet of a patient-centered medical home is the relationship between a patient and the provider team. Correctly identifying a provider's patient panel and being able to allow patients to self- attribute to a PCMP is a timely, convenient manner is key to affirming the patient-provider relationship and assuring the participants become a team.

Having two systems to attribute patients makes little sense to providers and patients, who often don't know their current attribution status. Allowing RCCOs direct access to record and update a member's PCMP choice regardless of the member's current attribution status will greatly improve the timeliness of attribution and the continuity of care for members. PCMPs and members will have confidence that the attribution to the provider of choice happened quickly and accurately, and the patient-provider relationship can be solidified.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

Collaboration should exist at the local level between RCCOs and local public health agencies (LPHA). Each LPHA is structured differently to meet the needs of its jurisdiction as are RCCOs. LPHAs and RCCOs can find ways to work together to serve clients in common. HCPF and CDPHE can provide guidance or highlight successful partnerships, but should not prescribe collaboration.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

Collaboration should exist at the local level between RCCOs and local departments of human services (DHS). Each DHS is structured differently to meet the needs of its jurisdiction as are RCCOs. DHSs and RCCOs can find ways to work together to serve clients in common. HCPF and CDHS can provide guidance or highlight successful partnerships, but should not prescribe collaboration.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

Collaboration should exist at the local level between RCCOs and local grantees with Connect for Health CO insurance navigators, often community social service agencies. RCCO already have partnerships with many

Connect for Health CO sites. Collaboration could be expanded to sharing eligibility files to enable RCCOs to proactively assist newly eligible Medicaid clients to select PCMPs.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

HCPF, DORA and DOI should be consistent in their conceptual framework for the ACC program. Regulations should support the ACC, and RCCOs should not be placed in the position of negotiating different requirements from state departments. We recommend establishing conceptual frameworks for defining financial risk between DOI and HCPF.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

RCCOs should be required to continue to utilize the current Performance Improvement Advisory Committee (PIAC) structure to provide input into the contractor's implementation and ongoing management of the ACC program. The PIAC should continue to involve members, client's families, client advocates, and advocacy organizations that interact with mutual members. The contractor should have a PIAC that represents stakeholders from across its geography. At least one member of the PIAC should represent the Medicaid-Medicare community in an effort to improve innovation and collaboration efforts for the Medicaid-Medicare Program where possible. RCCOs should also ensure that engagement with clients, their families, and advocates includes a diverse representation that ensures the RCCO is responsive to community needs and encourages building of a medical neighborhood to include behavioral health providers, PCMPs, and non-medical providers. The PIAC should continue to be required to meet at least quarterly, with minutes posted to the contractor's website, and RCCOs should complete PIAC projects in a reasonable time frame to promote member engagement and innovation. Members have different health beliefs, and opinions, on how they receive care, therefore, member focus groups may continue to be useful in ensuring that RCCOs are able to adjust to varying local community and member needs specific to their unique region. RCCOs should also continue to be required to promote member education and healthy lifestyle choices in a manner that is appropriate for the respective region (newsletters, decision aids, etc.).

Bidders in the RCCO process should demonstrate active engagement with the local community and clients served. Bidders that can demonstrate this engagement should be awarded additional points in the scoring system.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

Again, the PIAC should remain as a requirement for RCCOs as the committee provides for member, provider, community, and social service provider engagement in a forum that promotes collaboration and accountability amongst the local community. Moreover, RCCOs should be required to put in place guidelines that facilitate stakeholder engagement across RCCO boundaries where appropriate. In order to promote ongoing feedback, process improvement, and innovation RCCOs should be required to regularly survey providers, community organizations, and social service providers to glean specific feedback that can be used to improve care coordination, overall engagement, and build upon comprehensive care coordination, integrated care, and a patient centered medical neighborhood. Suitable suggestions made by stakeholders should be implemented in a reasonable time frame as deemed appropriate by the RCCO. The RCCO should be able to adjust to the feedback of stakeholders in a way that allows for local variation amongst each community.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

It is crucial that RCCOs are able to respond to the unique needs of their respective communities. Much work has been done to establish and maintain relationships within local communities. In HCPF's scoring and RFP

should award extra points for community involvement. It is important to create community involvement that demonstrates the responsiveness of RCCOs to their community and ensures stakeholders have a vested interest in the success of the RCCO. RCCOs should also work with their respective communities to reduce duplication of services, eliminate redundancies, and/or collaborate where appropriate in an effort to streamline services, refer to appropriate resources, and build upon referral networks which can positively impact the medical neighborhood as well as health and wellbeing of the member. It also may be beneficial to communicate opportunities for public comment, specific to the work of the RCCOs, with an ever-widening net to ensure the uniqueness and diversity of each community is represented. Enhanced community engagement may also be created through an annual Colorado ACC conference that provides opportunities to share best practices, successes, collaborate, and create deeper community engagement.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

The Department should continue to require that RCCOs submit a regular Stakeholder Feedback report that describes the contractor's work in collaborating with stakeholders, a summary of stakeholder feedback, trends, issues, complaints, and proposals to solve issues. The Department should allow for RCCOs to be less prescriptive in how they address issues, which allows for local variation and ensures a local patient centered approach that better meets the needs of the individual than a population specific approach. Stakeholder engagement is critical to the success the ACC. Ongoing regular consultation, involvement, and broad inclusivity of stakeholders will remain important in steering ACC initiatives, promoting shared accountability, two-way engagement, and collaborative decision making that allows for flexibility by region. Stakeholder engagement should not merely be a public exercise but a way to engage in issues that matter to the respective community, which goes beyond reporting, where information is used to make critical decisions. In that, it's important to tie stakeholder benefits to the goals of the ACC where appropriate. RCCOs should be able to demonstrate and report on their successes, as well as lessons learned, through interacting with stakeholders and be allowed to adjust programming as appropriate while ensuring the Department is well informed through a regular reporting process.

The Department may want to consider how local PIACs fit into the state-wide PIAC structure in the next RFP.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

No.

a. If no, what are the gaps?

Not enough specialty and behavioral care.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

There are gaps in specialty care for children.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

Hospitals need to better coordinate social support services with community services.

b. What role should pharmacies play in the next iteration of the ACC Program?

Pharmacy data needs to be available for the RCCOs.

c. What role should specialists play in the next iteration of the ACC Program?

Specialists will get involved if the financial incentives are there.

d. What role should home health play in the next iteration of the ACC Program?

Home health care and access to their data for transitions of care is critical for the MMEs.

e. What role should hospice care play in the next iteration of the ACC Program?

Hospice care will also be vital and their data must integrate and be accessible.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

SEPs and CCBs seem to be doing fine. Need to look at better communication and data sharing between Medicaid and Community Living departments at HCPF.

g. What role should counties play in the next iteration of the ACC Program?

Counties' public health data should better integrated with HCPF and RCCOs.

h. What role should local public health agencies play in the next iteration of the ACC Program?

See 44g for more information.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

Community organizations' funding where services are directly tied to providing medical or behavioral health care should be funneled through the RCCOs or integrated in a way to facilitate better transitions of care support at the state level.

45) How can RCCOs help to support clients and families in making and keeping appointments?

RCCOs must leverage current community organizations. Payment systems at the state level need to be modified to better facilitate this. See 44l for more information.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

No. The next RFP should require the bidder to articulate how they will create or support a system of care coordination that meets the requirements of the clients and community. Bidders should be required to demonstrate an on-the-ground, local care coordination system that conducts the activities and determines how they best serve the needs of our clients. The Department should require skills, not specific job titles.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☒
On staff (salary) at Primary Care Medical Provider Clinic	☒
On staff (salary) at RCCO	☒
Per Member Per Month Payment	☒

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

Partnership only with dental providers, unless the state significantly changes the adult dental benefit.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

It covers the spectrum from language, religion, education, age, and any life experiences that if not understood, could hinder care for the client.

b. What RCCO requirements would ensure cultural competency?

Requirements with a financial stick and/or carrot attached would better ensure cultural competence is taken seriously by all providers and is applied consistently to all clients.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

Skills needed would be active communication and a non-judgmental attitude. These skills should be taught and reinforced by regular training activities.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Consistent training on health disparities, the effects of poverty, and communication will address these inequities. RCCOs should be free to determine what training should be offered to accommodate differing needs of communities.

S0) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

As RCCOs evolve and begin to resemble Qualified Health Plans in their focus on the Triple Aim, RCCOs will need to have the expressed support and approval from HCPF and Centers for Medicare and Medicaid Services (CMS) to develop preferred networks of specialists, facilities and ancillary providers. The primary purposes of these networks would be to increase timely access to specialty care, improve outcomes, and decrease overall cost for Medicaid beneficiaries who have specific conditions or diagnoses. This allows for natural referral patterns within communities to be honored.

To be clear, CHP is not recommending that patients be restricted to these preferred providers to obtain specialty care. Patients would have the choice to obtain care from any willing provider; however, the CHP PCMPs and care management teams will recommend these selected programs and selected providers to their appropriate patients, as they will be able to obtain timely access and closely coordinate care with these selected providers.

The RCCOs will also need HCPF/CMS' expressed understanding and approval to provide incentives to patients to choose to obtain their care from the preferred network, to stay within the selected network during the course of treatment, and to complete a recommended course of treatment. For example, these incentives might include such mechanisms as waived copays, transportation or arranged child care.

Unless specifically defined in the agreement between HCPF and the RCCO, or in a subsequent payment reform program, HCPF would retain all responsibility for claims payment and would retain risk for services rendered by these preferred network providers. Claims would continue to be billed as fee for service (FFS). The RCCOS will develop formal administrative agreements or 'compacts' with these providers, outlining the access standards, goals, metrics and administrative procedures of specific programs. Any additional funding that may be required to develop and make these programs successful, beyond FFS payment, will be the responsibility of the individual RCCO.

S1) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Change the benefit structure on incentivize using primary care by making it free. Financially dis-incentivize ER visits by increasing co-pay and allowing for triage at ER to not serve non-emergent presentations. Emergency department patterns vary distinctly by region, making the ability of a RCCO to intervene in ways that are community-specific critical to success.

S2) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

See #S0 for more information.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☒	☐	☒	☐
Provide health and functioning questionnaires	☒	☐	☒	☐
Provide chronic care templates	☒	☐	☒	☐
Provide registries	☐	☒	☐	☒
Offer client reminders	☐	☒	☐	☐
Offer client self-management tools	☒	☐	☒	☐
Offer educational materials about specific conditions	☒	☐	☐	☐
Supply behavioral health surveys	☒	☐	☐	☐
Supply other self-screening tools	☒	☐	☒	☐
Administer behavioral health surveys	☒	☐	☒	☐
Administer other self-screening tools	☒	☐	☒	☐
Prepare client action plans	☒	☐	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☒	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☒	☐	☐	☐
Provide standing pharmacy order templates	☒	☐	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☐
Provide directory of other resources	☒	☐	☐	☐
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others: Patient satisfaction tools and measures				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

Training on cultural competency and practice specific data tools. This could be provided through health information exchange.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

The ability to assist practices in achieving PCMH status through an accredited agency is valuable. More importantly, however, is the flexibility to meet practices "where they are" in terms of transforming into medical homes.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

Provider financial support incentives that integrate behavioral and pharmacy, especially in smaller practices.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

use of registries would provide valuable data sources, but not sure it would assist PCMPs in their work without support from the RCCOs More comprehensive population-level data warehousing would be more useful in the long run.

58) Please share any other advice or suggestions about provider support in the ACC.

RCCOs need to provide assistance to practices on business processes to make them more efficient. Additionally, practice support should be based on the needs of a specific practice, not on a formula. Flexibility and adaptability are required to support the variety in size, sophistication, and interest of our practices.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

No. Substandard Medicaid fee-for-service provider reimbursement rates, even when combined with RCCO provider PMPM payments, provide little financial incentive for PCMPs and specialists. Reimbursements are not adequate to finance medical home models. We must institute more innovative ways to deliver cost-effective care. Some type of shared savings will be instrumental to any solution. Furthermore, the siloed and differing forms of payment for medical and behavioral health do not serve to support an integrated model. At the very least, the behavioral health capitation needs to expand the provided scope of services to enable reimbursement for access and intervention.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

In some cases, yes. Medicaid providers serve low-income populations, and some may require extra assistance in building ACO client-capacity. Larger providers are often better staffed and trained to deliver the services critical to medical home success and consequently, a value-based reimbursement system would likely favor those entities. Some of the barriers to smaller, less mature, or minimal Medicaid practices include strained and less adequately trained clinical and administrative staff, antiquated records systems, absence ofelectronic medical records, and inability to manage expanding regulatory requirements. Inefficient processes quickly translate to higher costs and mitigate the advantage of value-based payment systems. Finally, it is important to keep in mind providers are strained with similar, but distinct care management mandates from other insurers, often adding yet another obstacle to uniform care delivery. Aligning value based payments with what is demanding by commercial payers could help ensure success.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

CHP is not currently licensed by the DOI; however we, along with the other two RCCOs that are not currently licensed as HMOs, have had discussions with the DOI and HCPF about requirements to take risk. Medicaid is not an insurance program, and the RCCOs are not in the insurance business. Although Medicaid functions as a health plan in some ways, Medicaid beneficiaries are not sold, and do not buy, insurance policies; rather they are covered based on entitlement to benefits of a program pursuant to federal and state regulations. We believe that HCPF currently has the authority to establish risk arrangements with RCCOs and are open to continued discussions on appropriate requirements.

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

As RCCOs work to develop relationships with PCMPs to drive care delivery system transformation, having closer involvement of the RCCOs in capitated and pay for performance payment delivery is a critical measure to encourage PCMPS to work with their RCCO partners. Having PMPM payments run through RCCOs will help PCMPs acknowledge the role of the RCCO in supporting members with care coordination and PCMPs with practice support.

Allowing RCCOS to determine how pay for performance and shared savings payments are distributed to providers in the RCCO will allow more leverage in driving service delivery transformation and building the health neighborhood. For example, RCCOs can pass through incentives to PCMPs based on individual performance. RCCOs can also reward non-PCMPs for their role in meeting performance indicators and shared savings.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

We must create more robust systems of quality measurement and evaluation of payment reform pilot programs, ones which align financial incentives and support ACO capacity-building. RCCO incentive and shared-payment capacity must be directly tied to their ability to manage population health and improve outcomes. And, to determine the most efficient care management activities needed to deliver those quality outcomes, it is imperative RCCO's have access to timely data, particularly data which drives agreed-upon KPI's.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

The state should consider the following:

- Have consistent measures over longer periods of time and solid methodology for measurement
- Discover KPIs that align with commercial plans to reduce administrative burden
- Choose measures that balance cost and quality
- Choose process measures for chronic conditions; measure prevention and wellness; use HEDIS measures
- Measures should be adjusted by risk weights or acuity of population
- Total cost of care should be reduced by percentages in yearly increments

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	The CAHPS is useful, and the ability to drill down further into the data sets would be useful in making local decisions.
SF-12 Health Survey	☐	☒	This is not a measure of satisfaction or experience, but patient perception of his/her health status.

Other types of client interviews / surveys	☒	☐	Interviews and surveys with open ended questions are useful, on many levels, to measure patient experience. While Likert scale questions are useful, open ended questions provide for a better snapshot of patient experience. Volume of surveys and geographic distribution would be important considerations.
Patient Activation Measure	☐	☒	This is not a measure of satisfaction or experience, but the patient's engagement.
Focus groups	☒	☐	Focus groups are very useful but heavily biased toward who shows up, but should be regionalized to ensure the overall true patient experience is captured in each respective community. Engaging in focus groups in metro areas alone does not provide for an accurate picture of patient experience in rural or frontier areas where patient needs are different.
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

It is very difficult to pull meaningful health outcomes and population health data from claims. Population health measures should be adopted only when a community (or the state) has the means to collect the data. This may mean different timelines for different RCCO regions.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

It is imperative RCCO's have access to timely data, particularly data which drives performance in KPIs. Dashboard-level information should be supported by raw data, for both RCCO's and PCMP's. Quality also equates to eliminating redundant processes and efforts. At present, RCCO's receive data from multiple sources, much of it duplicative, infrequent, and stale. Any efforts in movement towards a single source (all-claims) data base would likely improve patient care delivery and reduce costs.

69) **Measures for payment**. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐

31-40	☐
41-S0	☐
S1+	☐
None	☐

Regardless of how many measures the Department selects, the measures should be fully vetted prior to announcement or implementation. It is unhelpful to announce performance measures tied to payment without providing a baseline, the calculation methodology, and time for RCCOs and PCMPS to prepare for interventions. Also, performance measures should hold steady over a longer period of time to allow for accurate measurement and the ability of RCCOs and PCMPS to make adjustments to interventions during the measurement period. Advantages gained from having RCCOs and PCMPs focus on multiple performance indicators may be quickly offset by the efforts expended in establishing them and collecting data need to measure them.

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-S0%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

The answer here depends on the nature of the payment model proposed in the next RFP. As payment reform gradually moves from fee-for-service to more capitated models, the need for performance incentivizing will lessen, as payees will fundamentally improve performance in order to remain competitive. In the initial stages of payment reform, we believe RCCO risk (value-based compensation) should be minimized.

And for now, the State should also maintain a payment model that recognizes there will be some level of upfront costs for both RCCO's and PCMP's – again, one with more predictable payments which allow entities to build critical infrastructure.

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Yes. Health care delivery maybe be marginally unique from community to community; however, the general model and objective of the accountable care model are consistent.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Every state is different, and ACO models vary. It would therefore be best to measure performance on improvement, as has been done thus far.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

No. The frequency and availability of data should have no bearing on payments. RCCO's understand the constraints inherent in claims-based measurements. So long as the payment model employed allows for adequate upfront payments, frequency and timing of incentive-based compensation are less critical.

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☒

If you checked the "Other" box, please describe payment frequency below:

Incentive payments should be made as soon as possible after performance has been measured. We would advocate for at least quarterly distributions, and more frequently than that, if the cost and effort required doing so did not exceed the benefit.

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

RCCO fixed costs are derived from the design of the quality and reporting, network development, care management and customer service components of the accountable care model. There are infrastructure fixed costs as well, such as facilities costs, supply costs, legal costs, and insurance costs, among others required to run a business.

Fixed/start-up costs include creating the financial, legal, and reporting infrastructure; contracting with vendors and providers that may provide services to the RCCO; and developing processes for care coordination, quality assurance, quality measure reporting, beneficiary engagement, and community involvement.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☒
Web portal	☒	☐
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☐	☒
Smartphone app	☐	☒
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☐	☒
Electronic Health Records (EHRs)	☐	☒
Health risk assessment software	☐	☒
Practice assessment tools	☒	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☒
Patient education/wellness tools	☒	☐
Provider/case manager directory	☒	☐
Shared decision-making tools	☐	☒
Telemedicine software	☐	☒
Other: health information exchange	☐	☒
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-S, where 1 are those items least-likely to be used, and S are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☐	☒	☐
Health risk assessment software	☐	☐	☐	☒	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☒
Patient education wellness tools	☐	☐	☐	☐	☒
Provider/case manager directory	☐	☐	☐	☒	☐
Shared decision-making tools	☐	☐	☐	☒	☐
Telemedicine	☐	☐	☐	☒	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

The deficits caused by lack of functionality and high cost are the primary barriers in adoption of HIT. There must be a defined return on investment in order to convince providers to change their workflow beyond meaningful use and other federal incentives. Multiple log-ins have significant impact on the practice workflow and can provide distinct barriers to providers accepting Medicaid into their payer mix. HIT should be more aligned with commercial and Medicare payer systems to provide efficiency.

81) How can Health Information Technology support Behavioral Health Integration?

Data that resides in both behavioral health EHRs and medical EHRs must be integrated in order for care to be integrated. Only by sharing a virtual community health record and care plans can we accomplish seamless integration of care between these two systems of care.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

While data analytics are very important, more resources need to be pushed down to the providers to allow for adoption of sharing their information in near real time to better manage outcomes and cost (see #84 for more information). The statewide data and analytics platform, based solely on claims data, is useful in providing patient stratification and for tracking RCCO and provider performance consistently, but cannot provide data on health outcomes. Looking at health outcomes is essential to the fundamental goals of the ACC program as well as the Triple Aim. To make it more useful, communities need the ability to query claims data for standard and ad hoc reports as necessary.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

Care management tools are useful in tracking and documenting care coordination activities and provide a valuable component of an overall HIT communication strategy. Many providers already have their own care management tools, and requiring them to adopt a statewide shared tool will create distinct workflow and cost barriers A better solution is to connect disparate EHRs through HIE to create real time access to a consolidated virtual community health record for each patient

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

Absolutely. Whether it is statewide or community based, providers and payers need access to data analytics which are available only through data warehousing. The warehouse should have the ability to aggregate and report clinical measures to health plans, quality assurance agencies, and providers without chart extraction (see #87 below for further information).

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

Health information Exchange is the ideal solution, based on a comprehensive model that includes real-time data from providers throughout the system of care (please see #88 for more information). HIE will establish virtual community health records containing longitudinal medical information compiled from hospitals, physician groups (primary and specialty), pharmacies, and ancillary providers. This would also facilitate communication between providers for clinical referrals and behavioral health integration. Ideally, the system would provide alerts into practice EHRs to notify providers about opportunities for preventive or follow-up care.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

Health Information Exchange and consolidated community Personal Health Records (PHR) that tie directly from data in the HIE are essential to providing comprehensive care coordination across systems of care A community-based population and public health data warehouse with actionable information will provide the basis for meaningful and measurable programs to improve the health of the community, enabling the health neighborhood to better understand and manage integrated care (please see #90 for more information).

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

RCCOs, as community-based facilitators, should assist with facilitating, training and investing in connection of HIEs, establishing population-based data warehousing and data analytics whenever possible to establish community-specific integrated solutions to support broadly defined health neighborhoods (including medical, behavioral, and social services providers). RCCOs can also play a role in making care management tools available to support care coordination.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

CORHIO, QHN and other HIE platforms can help provide the hospital data they are already connected to and are an integral part of the solution. To maximize their potential, these platforms must be community supporters and system integrators with community-based solutions. (see #90 for further detail).

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Health Information Exchange (HIE) should be regionally based to accommodate the needs of different communities. HIE is essential to care coordination. Equally important is access to data analytics at the population level to enable communities to identify and address issues and opportunities within the health neighborhood.

While care management tools are very useful in coordinating care among providers, we need to invest in connecting EHRs through system integration first. Because of practice workflow, care management tools may not be adopted by all providers.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 078

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Community Reach Center
Location: Thornton, CO 80260

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Click here to enter text.
Location: City, County, State.
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: CMHC
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Due to owning a pediatric practice, Community Reach Center is involved and engaged with the RCCOs

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
We are a community mental health center serving Adams County in Colorado

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☒ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Are you currently involved in the ACC program?

☐ Yes
☒ No
☐ I don't know

Please feel welcome to describe why or why not using the space below.

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Better collaboration
- Better understanding of the system, strengths, challenges
- Sharing of information

2) What is not working well in the ACC Program?

- EDs are not part of the solution, so hard to keep consumers out of the ED when there is a billboard advertising less than a 10 minute wait.
- All of the new 'pop up' ERs that increase access to the highest level of care
- BHOs and RICCOs don't align
- CMHC not a patient center home even though some patients prefer to come through the door of CMHC; disconnect from medical requirements and behavioral health requirements; medical home model does not fit with Behavioral Health

- Billing and coding not aligned to have an integrated practice
- Medically focused. Behavioral health is being recognized, but often as an afterthought.
- CMHC have a long history of treating the whole person, care coordination, addressing social needs like housing, etc., while physical health care has not historically had the structure or system to address the whole person's needs.
- Trying to fit Behavioral Health into the medical model verses reforming the system

3) What is working best in the Behavioral Health Organization (BHO) system right now?

- Good coverage
- Treats a wide range of disorders
- Formal structure for consumers to be represented
- BHI has NCQH standards that improve quality of care
- Integrated care works well and makes sense for patients
- UM function provides a nice checks and balance, helps build community based services and helps keep down costs
- Helps maintain consistency
- The risk based payment model enables the BHOs and their provider network to create a person-focused, integrated healthcare delivery system that is focused on addressing the needs of the individual and communities.
- Provides behavioral, physical and human services to improve health outcomes
- Risk Based payment model allows for a system to manage and pay for the care for people with significant and complex needs

4) What is not working well in the BHO system?

- Significant amount of time spent on tracking, analysis and providing data to the BHOs that don't necessarily focus on the value of the work or outcomes that are important to consumers
- Focus on the encounter verses health outcomes

5) What is working well with RCCO and BHO collaboration right now?

- Open communication and working on building a strong partnership/ collaboration
- There is a palpable desire for working collaboratively across groups invested in integration e.g. Department of Family Medicine, BHO, RCCOs, PCMPs, substance use treatment, prevention, mental health, departments of government, to efficiently plan for integration.

6) What is not working well with RCCO and BHO collaboration right now

The two systems need better communication and alignment of goals as well as policies and procedures. Outcomes will continue to suffer if the two systems are not communicating well and working well together. It is often the high utilizers who are involved in both systems.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- Align RCCOs, BHOs and commercial insurance in order to achieve goals of the ACC, improve patient care
- Focus on value vs. volume/ encounters
- Address regulatory burden and payment structures that prevent quality work
- Focus on services vs. administrative burden.
- Streamline reporting and processes
- Primary Care documentation requirements are very different from Behavioral Health. If true integration is going to occur, need for the two systems to better align in documentation, assessment and treatment planning processes
- Payment system should support integration and treatment of the whole person
- Open up codes to allow for BH billing with physical health care issues; BH providers are the experts in behavioral change; more change can occur if BH providers are able to work and bill for services with individuals who have diabetes, cardiac conditions, etc. making change in diet, exercise, etc. is difficult and requires more than medication and quarterly appointments with their PCP
- Integrate RCCOs and BHOs
- Have care coordination follow the individual and the place where they want to be served. CMHCs have a long history of providing care coordination. Even in the current system, PCP rely on CMHCs to provide the care coordination, but they receive additional payment for those services
- Integrate funding for comprehensive healthcare to explicitly include behavioral health
- Place the patient at the center of healthcare and surround that patient with appropriate comprehensive services

[1] Many terms and definitions can be found in the Appendix at the end of this document.

- Focus on development of outcome measures that are consumer-generated, and consumer available and utilized, rather than focusing on clinician-generated outcome measures.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	Currently you must have a mental health diagnosis to receive reimbursement for services. These services must meet the coding manual requirements which can be vague at times.
Community Behavioral Health Services Rule	☒	☐	Numerous rules and regulation require a large amount of paper work and assessment/reassessment time (i.e. treatment plan reviews, duplicate assessments/documentation). This is often a deterrent to consumers due to the amount of time this takes away from actual treatment.
Covered diagnoses list	☒	☐	Current list of covered diagnosis under capitation is limiting.
Different behavioral / physical health reimbursement	☒	☐	
Institutions for Mental Diseases exclusion	☐	☐	

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	
PCMP financing structure	☐	☒	
Per-member per-month amount	☐	☒	
Physical space constraints	☒	☐	
Privacy Laws (HIPAA, 42 CFR)	☒	☐	Due to the federal nature of limitations with 42 CFR, a task force should be developed to include behavioral health and physical health stakeholders to discuss a consistent methodology for information sharing within the limitations of HIPAA/42 CFR.
Professional / cultural divisions	☒	☐	
RCCO or BHO contracts	☒	☐	
Staff capacity	☒	☐	Workforce Development is needed. There is a shortage of psychiatrists, psychiatric nurses, and Licensed Clinical Social Workers.
State/Federal rules or reporting requirements	☒	☐	
Technical resources / data sharing	☒	☐	
Training	☒	☐	There is currently very little cross training between mental health and physical health.
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

The current strong collaborative partnerships that are in place are viable, however are not bridging the gaps at this time. There is a need for a more formalized information sharing structure that has shared language, goals and accountability. An integrated and shared financial structure that allows codes for mental health within physical health settings is also need. In addition, current staffing is not reflective of true integration as the ratio of behavioral health professionals to physical health providers is not balanced.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

It has taken a long time and a great deal of work to breakdown the cultural and communication barriers between behavioral health and physical health. As we move forward with true integration, the process needs to start with a shared vision and that accounts for the cultural differences and the strengths of the different communities and their partners. Community Reach Center would like to see a commitment to:

- Fully integrate behavioral health providers into medical healthcare settings
- Integrate funding for comprehensive healthcare to explicitly include behavioral health
- Establish and promote inclusion of behavioral health as necessary to the success of Patient-Centered Medical Home, Accountable Care Organizations and other team-based, patient-centered, and quality driven delivery initiative
- Place the patient at the center of healthcare and surround that patient with appropriate comprehensive services
- Develop training standards and curricula that support comprehensive integrated healthcare

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

Treating the whole person to support the healthiest life style as possible. Addressing all needs of the person, regardless of type of need (medical vs. non-medical). It involves the deliberate organization of patient care activities between two or more participants involved in a patient's care.

b. How should RCCOs prioritize who receives care coordination first?

With consideration of the "whole" person, it should be "How should the system prioritize who receives care coordination first, not the RCCOs as it does not address all of the care coordination that is provided outside of the RCCOs. This prioritization should be done based on need/ known high risk factors, meeting the triple aim and the goals established by the state. Care Coordination should focus on those that present the highest physical and mental health risks for mortality, as well as the highest utilizers of multiple systems.

c. How should RCCOs identify clients and families who need care coordination?

The entire system should have access to a common database such as CORIHO which would allow for the identification of those with high risk situations, cases outside of the triple aim (i.e. access is one of the aims, data shows that a consumer has not been able to access a needed service, that should trigger care coordination needs).

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

The practice should be responsible for reporting the number of patients with a care plan, number of contacts in a month, number of employees providing the care.

12) What services should be coordinated and are there services that should not be a part of care coordination?

If the goal is to be patient centered and to treat the whole person, all things should be part of care coordination as we need to ensure that the individual's housing, social, day care, employment needs are addressed

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

In order to assess the care coordination needs of the client, a brief assessment of the major domains (i.e. health, vocational, education, social, housing, etc.) should be completed, the diagnoses, systems they are already in, and unmet needs to be addressed in order to be successful.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

A tremendous amount of care coordination occurs at the Community Mental Health Center. Providers address behavioral health needs, collaborate with primary care providers, attend to housing, employment, education etc. The higher risk consumers require significantly more care coordination as they are often involved in numerous systems.

Additionally, care coordination is happening at PCMHs, nursing homes, child welfare and early intervention programs.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

As mentioned above, Community Mental Health Centers do a tremendous amount of care coordination.

This coordination is best captured with the quote below:

> "If a person doesn't have a roof over their head, if they don't have a meal, if they're a victim of physical or sexual abuse if their household has a lot of stress in it, if their kids' school is not safe, then that's going to impact their health.....that health is more than just the pill that we're giving you or the hospital that we put you in. It's all the other parts of your life and whether they're working in harmony."
> Dr. Jeffrey Brenner in interview "What Primary Care has to Learn from Behavioral Health". National Council for Behavioral Health.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

Care coordination needs to follow the client and be in a place that is convenient and preferred by the client. Many clients prefer to come to Community Mental Health Center for their care coordination as this is where the majority of the coordination takes place. Community Mental Health Centers have a long history of care coordination. By attending to all needs, they have demonstrated success with keeping clients out of the hospitals and reducing costs under the full risk capitation system

d. What are the gaps in care coordination across the continuum of care?

Care Coordination is often not well-defined, with a variety of care coordinators within the different silos providing care coordination to meet the needs of their particular agency/mandate. Often care coordination is unfunded which can create a financial barrier for providers.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	Should the RCCO have a role? No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☒	☒	
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	
Daycare / childcare	☐	☒	☒	
Economic stability & employment	☐	☒	☒	
Education	☒	☐	☒	
Environment	☐	☒	☒	
Food access / nutrition	☒	☐	☒	
Health literacy	☒	☐	☒	
Housing	☐	☒	☒	
Language or translation services	☒	☐	☒	
Literacy	☐	☒	☒	
Transportation	☒	☐	☒	
Other				

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	Work with other professionals and lay persons involved in the case
Certified Addiction Councilors	☒	☐	""
Certified Nurse Midwives	☒	☐	""
Community Health Workers	☒	☐	""
Generalists (BA/BS/MA/MS)	☒	☐	""
Health Coaches	☒	☐	""
Licensed Clinical Social Workers	☒	☐	""
Licensed Marriage and Family Therapist	☒	☐	""
Licensed Mental Health Counselors	☒	☐	""
Licensed Professional Counselor	☒	☐	""
Masters of Public Health	☒	☐	""
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	""
Nurse Practitioners	☒	☐	""
Patient Navigators	☒	☐	""
Peer Advocates	☒	☐	""
Promotoras	☐	☒	
Psychiatrists	☒	☐	""
Psychologists	☒	☐	""
Registered Nurses	☒	☐	""
Social Workers	☒	☐	""
Wraparound facilitators	☒	☐	""
Other			

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☒	
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☐	☒	
Children involved in the foster care system	☒	☐	Special population has special needs, like determining where the youth should live. Having a care coordinator who understands all of the needs are therefore are about to address court/ custody issues.
Children with a chronic illness	☒	☐	Like with other special populations, having a competent care coordinator who understands the population, challenges, and needs are critical to achieving health outcomes.
Children with a serious emotional disturbance	☒	☐	Like with other special populations, having a competent care coordinator who understands the population, challenges, and needs are critical to achieving health outcomes.
Children with medical complexity	☒	☐	Like with other special populations, having a competent care coordinator who understands the population, challenges, and needs are critical to achieving health outcomes.
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	Like with other special populations, having a competent care coordinator who understands the population, challenges, and needs are critical to achieving health outcomes.
Transition-age adolescents	☒	☐	Like with other special populations, having a competent care coordinator who understands the population, challenges, and needs are critical to achieving health outcomes.
Parents and families	☐	☒	
Pregnant women	☐	☒	

Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☐	☒	
Adults with a chronic illness	☒	☐	Like with other special populations, having a competent care coordinator who understands the population, challenges, and needs are critical to achieving health outcomes.
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	Like with other special populations, having a competent care coordinator who understands the population, challenges, and needs are critical to achieving health outcomes.
Clients involved in the criminal justice system	☒	☐	Like with other special populations, having a competent care coordinator who understands the population, challenges, and needs are critical to achieving health outcomes.
Clients with a disability	☒	☐	Like with other special populations, having a competent care coordinator who understands the population, challenges, and needs are critical to achieving health outcomes.
Clients in a nursing facility	☒	☐	Like with other special populations, having a competent care coordinator who understands the population, challenges, and needs are critical to achieving health outcomes.
Elderly clients	☒	☐	Like with other special populations, having a competent care coordinator who understands the population, challenges, and needs are critical to achieving health outcomes.
Frail elderly clients	☒	☐	Like with other special populations, having a competent care coordinator who understands the population, challenges, and needs are critical to achieving health outcomes.
Clients in palliative care	☒	☐	Like with other special populations, having a competent care coordinator who understands the population, challenges, and needs are critical to achieving health outcomes.
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

- The establishment of Complex Care Teams providing a multidisciplinary approach to complex care coordination.
- Ensuring that there are strong community resource partnerships
- Identifying standardized best practice interventions
- Assessing Behavioral Health Needs /Physical Health Needs-Medication Needs/Community Resource Needs

19) How should care coordination be evaluated? How should its outcomes be measured?

Identifying the value of care coordination and that will help to define what should be measured. If the value is improving quality of care, decreasing costs, then those would be reasonable outcome measurements. However, assessing readiness for the system is important. We believe initially, a care coordination program should be measure by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for clients. Initially all measures need to be quite separated from outcomes that are highly tied to client behavior, or practices will be less likely to serve those with the highest risk.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

N/A

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

N/A

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

Not necessarily. Each community and population is different; what works for one population does not necessarily work for another population. In the event there is a move toward establishing a ratio, then the system should account for the acuity and population.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

A comparison of those high utilizers that are receiving care coordination (actually receiving rather than just being offered) to those that are not receiving care coordination would provide valuable data. Metrics developed should include usage of ER/ED, PCP, adjunctive services (behavioral health, specialty care) between those with and without care coordination. Metrics should include physical and behavioral health outcomes to include adherence to treatment regimens (i.e. diabetes, attendance at behavioral health services), improvement in overall functioning (GAF for behavioral health); length of inpatient stay for medical and behavioral health; consumer's perception of care coordination services received (i.e. patient feels more hopeful, patient feels as though someone is helping to navigate the system).

Another area for consideration would be to look at those individuals who are not yet 'high utilizers' and whether effective care coordination prevents them from moving into the 'high' category.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

- Consider aligning with Section 2703 of the Affordable Care Act for individuals with multiple chronic health conditions.
- Don't over regulate! Allow flexibility to determine what works best for the client. Again the focus should be on the value that care coordination brings to the client and the system.
- Focus on better health outcomes, improved quality of life and not creating more administrative burden.
- Care coordination is most effective when it's done at the point of care.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Streamline administrative burden, allowing local flexibility to enable providers to achieve the triple aim in the communities that we serve.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

No response

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

No Response

27) Should the RCCO region maps change? Why or why not? If so, how?

- The RCCOs and the BHOs regions should align in a manner that maximizes community partnerships and addresses community needs.

28) Should the BHO region maps change? Why or why not? If so, how?

- The RCCOs and the BHOs should align in a manner that maximizes community partnerships and addresses community needs.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

N/A

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

- Information sharing
- Resolving 42CFR challenges
- Streamlining behavioral health similar to physical health
- Payment reform

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

- Continuous eligibility is necessary to ensuring continuity of care, achieving outcomes and reducing long term cost;

- The loss of benefits impacts access, health outcomes and increases the administrative burden for the providers
- A change to allow for the instant enrollment in Medicaid if eligible, and when transferring Medicaid from county to county.
- There is no benefit structure that supports integrated care. HCPF will not cover behavioral health codes and the BHO's require mental health level of documentation that is impractical. Funding needs to be flexible and able to support the needs of the patient. There is a need to move away from a fee for service model to a value based system where good outcomes are the focus.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

- Having multiple RCCO's per region causes confusion and is not as efficient as one RCCO who has good relationships with community partners as well as the PCMH's.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

N/A

34) What role should RCCOs play in attributing clients to their respective PCMPs?

N/A

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

Collaboration on Disaster Response Efforts and Regulations for facilities.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

Collaboration needs to exist. Individuals and families involved with human services have a significant amount of needs, if health outcomes are to be achieved, treating the full person/family is critical.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

Necessary if we are going to address health outcomes for Coloradans, not just a Medicaid issue

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Work should be done to include private insurance as part of the ACC system. There are many services we can provide to Medicaid clients that we cannot provide for our insurance clients because it is not covered under their insurance.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

- Consumer Representative
- Consumer Advocate
- Consumer Rights

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

- Same as above

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

Allow the communities to function as the lead for creating their system of care with the support of parameters and guidelines to follow.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Through the PIAC's as well as some focus groups that engage community members as well as consumers. It would be helpful to see what the end user is experiencing as working and not working.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

No

a. If no, what are the gaps?

- Shortages of psychiatrists, nurses, LCSW's
- Waitlists for those looking for support for DD/ Autism/TBI

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

They have to become part of the solution as to the overuse of the ED's.

b. What role should pharmacies play in the next iteration of the ACC Program?

Communication around trends and problems they are experiencing.

c. What role should specialists play in the next iteration of the ACC Program?

We need to recruit more specialists to participate.

d. What role should home health play in the next iteration of the ACC Program?

They need to work closely with practices so care is coordinated and focused on good health outcomes.

e. What role should hospice care play in the next iteration of the ACC Program?

They need to work closely with practices so care is coordinated and focused on good health outcomes.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

No response

g. What role should counties play in the next iteration of the ACC Program?

They need to understand and support the overall outcomes of the ACC's and coordinate their efforts to help us manage difficult populations.

h. What role should local public health agencies play in the next iteration of the ACC Program?

They are a good resource for population health and management – they have many lessons learned that can be shared. They also need to play a role in the management of difficult populations.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

Many of these organizations have valuable lessons learned and are very good at engaging difficult to engage populations. These organizations should be at the table to help us learn, but also to partner around the management of special needs populations.

45) How can RCCOs help to support clients and families in making and keeping appointments?

- Address transportation needs, support telehealth, evaluate operations to ensure scheduling and appointments are convenient for clients.
- RCOOs should link with the various providers to discuss how site-specific improvements and strategies can be made to increase compliance with appointments.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

Not require but encourage.

47) **Community Health Worker reimbursement**. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☒
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

Work with dental providers to understand their role in providing oral health care to this population. Include dental providers as part of the medical home network.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

- Meeting the client where they are at with consideration the things that influence their behavior and the way they need to get support.
- Cultural competency is effectively providing services to people of all cultures, races, ethnic backgrounds and religions in a manner that respects the worth of the individual and preserves their dignity.

b. What RCCO requirements would ensure cultural competency?

- Focusing on good outcomes is the best measure. If your services are not culturally considerate of the client, the outcomes will likely suffer.
- Compliance of providers training all staff in CLAS Standard

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

- Good listening and engagement skills.
- Know how to utilize bilingual staff, interpreters, telephone interpretation services
- 'Market' services available in non-English brochures and materials distributed to the public
- Educate all staff on what services are provided
- Discourage use of family and friends as interpreters
- Staff should be trauma informed as a cultural shift for providing services
- Assess knowledge of medical terminology of interpreter candidates
- Stay informed of Tools to Reduce Disparities such as:
    - A Physician's Practical Guide to Culturally Competent Care
    - Culturally Competent Nursing Care: A Cornerstone of Caring
    - Health Care Language Services Implementation Guide
    - Cultural Competency Curriculum for Disaster Preparedness and Crisis Response

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Having a staff that is reflective of the demographic makeup of the practice would be helpful. Also recognizing that the health care work force is already unable to meet the demands, so when adding cultural and language capacity as a requirement, it gets that much more difficult to meet the demand for services.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

Pending payment reform, the BHOs and CMHCs have demonstrated that in a full risk capitated system, building strong provider networks is key to reducing costs while ensuring outcomes.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

- Engage hospitals and emergency rooms as partners in managing emergency room use. Currently, they have a financial incentive to treat non-emergent issues in the emergency room.
- More oversight by the State with regard to the number of pop up free standing emergency rooms is needed. These can be problematic as clients are not well educated on the fact that the appropriate use of the facility as an emergency room rather than a walk in triage clinic.
- Develop a way for the RCCOs to share more real-time data with providers so they can intervene while the client is in the emergency room.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☐	☒
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☒
Provide practice-specific data reports	☒	☐	☐	☐

Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☒	☐	☐	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☒	☐	☐	☐
Provide registries	☒	☐	☐	☐
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☒	☐	☐	☐
Supply behavioral health surveys	☒	☐	☐	☐
Supply other self-screening tools	☒	☐	☐	☐
Administer behavioral health surveys	☐	☒	☐	☐
Administer other self-screening tools	☐	☒	☐	☐
Prepare client action plans	☐	☒	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☒	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☒	☐	☐	☐
Provide standing pharmacy order templates	☐	☒	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☒
Provide directory of other resources	☒	☐	☐	☒
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

No response

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

No response

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

No response

58) Please share any other advice or suggestions about provider support in the ACC.

No response

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

While there has been some demonstrated success, the current system does not fully support the goals of the ACC in that the system still focuses on the providing a service to get reimbursed; fee for service models does not allow for creativity and leads systems to chasing the dollar vs. focusing on value and outcomes. The PMPM payment might work for primary care, but it leads to duplicative services, dollars going to providers who are not necessarily providing care coordination and is limited to primary care practices.

The ACC program should consider moving towards a risk-based payment model and away from a fee-for-service model.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

CMHC providers in Colorado have demonstrated how full risk capitation systems can work. We have great flexibility to provide the right services at the right time and at the right place as we work to meet the triple aim. We have reduced utilization of costly services, such as hospitalization, built strong community based resources and services and been nimble enough to meet the needs of our local communities.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Yes, but value needs to be measured appropriately and include items that providers can influence. Should focus on health outcomes instead of services delivered.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

No Answer

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

No Answer

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

Improvement in functioning and decrease in symptom severity (currently used by C-Stat) should be tied to diagnoses and other elements of functioning in order to determine if reasonable progress is being made based on what the consumer presents with, rather than treating all consumers the same. Other outcomes should also be reflective of current research, and use of best practices to treat specific populations.

Focus on consumer perception of outcomes. Rather than solely focusing on staff perception of improvement, have consumers rating their assessment of improvement during their episode of care. Relationship with the behavioral health provider is consistently shown as the strongest predictor of engagement by consumers and improvement, especially early on in treatment. Assessments should occur on a regular basis regarding consumer's perception of the care received by their providers at the various locations. Creative methods for outcome measurement should also be utilized such as measuring the amount of hope a consumer has in their recovery following their appointments with providers. Hope is also shown to be a strong predictor for future engagement in services, as well as decreased suicides.

66) **Measuring Client** experience. Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☒	☐	Consumer Advisory Panels at all sites to gain current patient/consumer feedback and input into services provided.
Patient Activation Measure	☐	☐	
Focus groups	☒	☐	
Other	Please type your response here. Use of Outcome Rating Scale and Session Rating Scale (Feedback Informed Treatment) http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=249 is an EBP that is designed to improve the retention of participants in treatment and to assist them in reaching reliable and clinically significant change. The program can be implemented by behavioral health care therapists as part of any behavioral health care intervention.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

Through data provided to the department, analysis of HIE data and claims data.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

No answer

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☒
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

Difficult to say as payment reform needs to be considered and pending the payment system, the % should be set on national standards.

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

The state should consider payment reform that moves toward a risk based payment model and away from a fee for service model as it incentivizes providers to assume and manage risk. This model for behavioral health has demonstrated achieving both financial and health outcomes.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

The recommendation is overall payment reform. Once a system is in place, metrics should be established that align Colorado's health outcome goals with national standards and meeting the triple aim. One key factor to consider is to calibrate performance based on where the system in Colorado is and working to achieve the national standards.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

See recommendation on payment reform to a risk based payment model, the model adopted will guide the details.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

No response

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

- Functional status
- Engagement
- Symptom Severity
- Hospitalization
- EBP outcomes
- Access to Care (time to first appointment from request, time response to crisis response, time to psychiatric appointment from initial evaluation, time to psychiatric appointment from hospital discharge:
- New State Crisis Services will measure:

- Timeliness of walk-in to being served at CSU
- Timeliness of dispatch to community-based crisis services
- Engagement in treatment planning
- Consumer's perception of satisfaction of crisis services
- Percentage of consumers that make or keep appointments following discharge from crisis services
- Decrease in suicidality from admission to discharge in crisis services

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☒
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☐	☒
Smartphone app	☐	☒
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☒
Patient education/wellness tools	☒	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☒	☐

Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-S, where 1 are those items least-likely to be used, and S are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☒	☐
Care management tool	☐	☐	☐	☒	☐
Care transitions alerts	☐	☐	☐	☒	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☒	☐	☐
Health risk assessment software	☐	☐	☒	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☒
Patient education wellness tools	☐	☐	☐	☐	☒
Provider/case manager directory	☐	☐	☐	☐	☒
Shared decision-making tools	☐	☐	☐	☐	☒
Telemedicine	☐	☐	☐	☐	☒
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

42 CFR: Colorado State regulations on Community Mental Health Centers (2 CCR 502- 1) previously required a release of information, signed annually, that specifically designated the entity the PHI would be released to. This changed to 2 years on 11-01-2013.

This would come into play in any level of integration (whether that be facilitated referrals, co-location or more fully integrated services) that involved a community mental health center partner, or managed services organization, or substance use disorder treatment provider partner

81) How can Health Information Technology support Behavioral Health Integration?

HIT can only support BH Integration if HCPF/OBH address 42CFR Part 2. Although integration has been a push for several years in 2013, OBH consolidated eight volumes of rules to one but made no regulation change regarding sharing of BH data except for moving from one year to two year release expiration. They did, however, add language to reinforce that HIPAA and 42 CFR Part 2 are to be followed.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

There is not currently the technology or capacity in the system to support electronic sharing of 42 CFR covered information even if a release is signed. Some CMHC's have been working closely with CORHIO however only sending mental health only information, not information on anyone co-occurring or SUD primary diagnosis.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

It might support the sharing of consistent information in a manner that is familiar to all parties. At the same time, we need to ensure that whatever is put into place, it is not there simply to track and add to an already overly administratively burdensome system.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

It seems too early in the process to consider this. It has taken years of working together to attend to cultural and communication differences between primary care, behavioral health and social services. There is potential, but need to consider when and how it would be used.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

- Provide both physical and behavioral health resources/ providers
- Provide links and contact information for ease of access
- Include some screening (like the PHQ 9) so that people can do some self-assessment and get connected to the correct resource

86) How can the RCCOs support providers' access to actionable and timely clinical data?

Ensure a user friendly system and access that is comprehensive and reflects real time data that supports treatment decision in the moment that will have a positive effect on health outcomes

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88)

No response

89) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

- Portal for the individual to access his/her information
- Support for the centers to create the file for information exchange

90) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

- Need a platform to be available to both physical health as well as behavioral health
- Critical that it allows for easy exchange of information
- Provides real time data that can be used to impact client treatment
- Support for the CMHC's to create the file for information exchange

91) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

- Advocacy at federal level around 42 CFR Part 2
- Colorado will need to address HIE as part of the State Innovation Model (SIM)
- CORHIO exploring granular consent model

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 079

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Anonymous
Location: City, County, State.

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Click here to enter text.
Location: City, County, State.
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☒ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☒ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs: Involvement with ACC includes advocacy and grant support for the evaluation. Involvement with RCCOs includes advocacy and grant support.

Please briefly describe your involvement with Medicaid, either in Colorado or another state: Involvement includes advocacy and grant support.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Children are being enrolled in ACC, and the well child visit KPI is a positive first step in measuring and promoting progress in children's health.

- HCPF has a great opportunity to do what is needed for the majority of Medicaid recipients: children and adolescents. They should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.
    - So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
    - Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
    - There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

- As ACC evolves into a system the promotes integrated care and clients' behavioral health, HCPF's definition of behavioral health care must: 1) move from an outdated disease-focused model to one that includes promotion, prevention, and early intervention and 2) reflect the unique needs of children, youth, and adults.
    - The current definition reads as follows. "Behavioral health care refers to all services to treat health conditions that primarily present as alterations in thinking, mood or behavior and changes in emotional (mood), psychological (thinking), or social well-being (behavior) and conditions related to addictions."

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- Successful integration of medical and behavioral health means the RCCOs and BHOs must also be integrated. They should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care. It would also serve clients much better.

- Care coordination for both behavioral health and medical care should be done in the primary care setting for the majority of clients. The RCCO and/or the BHO should delegate the responsibility to do care coordination and a PMPM to cover the expense to the medical home as part of the payment reform process. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Payment options for truly integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☒	☐	
Different behavioral / physical health reimbursement	☒	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

- As noted above, HCPF's definition of behavioral health care must evolve and : 1) move from an outdated disease-focused model to one that includes promotion, prevention, and early intervention and 2) reflect the unique needs of children, youth, and adults.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

b. How should RCCOs prioritize who receives care coordination first?

c. How should RCCOs identify clients and families who need care coordination?

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

- RCCOs must be incentivized to promote non-clinical care with an understanding of its impact on health outcomes. RCCOs can help medical homes address such client needs as housing, food, parental employment, child care, or help practices connect with other agencies that provide these services.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	
Health literacy	☐	☐	☐	
Housing	☐	☐	☐	
Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	

Transportation	☐	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

- All of the types of individuals below must be considered as potential members of care coordination teams. Practices should be given the latitude to decide who fits best with their model and their patients' needs.

Type:	**Coordinate care?** Yes	No	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	

Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	

Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

- A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐

101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

- Care coordination is best done in the medical home. They are willing to do care coordination, because they have a relationship with patients and they trust the providers. They also recognize that coordinating complex medical care is essential for good care and for cost savings. Primary care providers are best positioned to have a long-term relationship with the patient. They know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

- If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in a RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

- We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give HCPF the best chance of truly improving health and wellness in the long term, KPIs must be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 080

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Sam Murillo
Location: Centennial, Arapahoe, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Family Voices Colorado
Location: Centennial, Arapahoe, CO
✓ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
✓ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

✓ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
✓ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
FVC has been involved with ACC through Medical Home certification and Provider Recruitment and with RCCOs through policy advocacy interactions.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
FVC involvement with Medicaid includes Medical Home certification, Provider recruitment, direct client advocacy representation, policy advocacy eg boards/committees.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
✓ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

FVC will likely seek participation should the department recognize/acknowledge the need for systems navigation services as part of the triple aim and goal of the next ACC iteration.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

Provider support post-recruitment

Administrative clarity

Meeting basic health care needs of clients

2) What is not working well in the ACC Program?

Network adequacy

Knowledge of special health care needs

Transitions to adult providers

Lack of community-based contracts for navigation and advocacy

3) What is working best in the Behavioral Health Organization (BHO) system right now?

Administrative intervention

4) What is not working well in the BHO system?

Lack of universal quality between BHOs

Lack of quality service delivery for dual-dx in context of IDD/BH

Lack of flexibility if client is not being served well by their BHO

Lack of agency/provider accountability

Lack of community-based contracts for navigation and advocacy

5) What is working well with RCCO and BHO collaboration right now?

Administrative collaboration which improves clarity of service delivery

6) What is not working well with RCCO and BHO collaboration right now?

Routine quality care coordination that includes community-based contracts for navigation and advocacy

Making sure clients have access to information and service while also understanding process information

Lack of routine evaluation for accountability

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Real choice and access of providers

Safe problem-resolution if providers are named as a barrier

Seamless coordination and service delivery for dual-dx

Integration must acknowledge client-specific community-based navigation and advocacy is needed

Integration must acknowledge impact of social determinants of health to help realize meaningful engagement for consumers

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	✓	☐	Needs to based on quality services rendered so equity is part of delivery
Community Behavioral Health Services Rule	✓	☐	Universal implementation should not be subjective
Covered diagnoses list	✓	☐	Basing services on targeting criteria or dx is not person centered
Different behavioral / physical health reimbursement	✓	☐	Systems shouldn't be able to push responsibility secondary to a rate; this is not person centered
Institutions for Mental Diseases exclusion	✓	☐	IMD is limiting, not based on person centered planning and puts triple aim tenets at risk
OBH rules, reporting, or financing (regulatory differences between agencies)	✓	☐	There needs to be intra-agency communication and regulation-fusion where applicable
PCMP financing structure	☐	☐	
Per-member per-month amount	✓	☐	There needs to be more equity so services are better
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	✓	☐	These are different constructs. Inclusiveness practices and cultural responsiveness is a huge gap
RCCO or BHO contracts	✓	☐	Contracts need to include community-based navigation and advocacy
Staff capacity	✓	☐	Capacity needs to align with systems knowledge
State/Federal rules or reporting requirements	✓	☐	Not necessarily based on client experience
Technical resources / data sharing	✓	☐	Needs to be more transparent and fluid

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Training	✓	☐	Universally implemented training is a gap
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

Ability to deliver services to children with special health care needs including dual-dx

Transition when appropriate

Staff with systems knowledge

Ability to problem-solve non-medical barriers to care

Contemporary perspective of care coordination that includes navigation and advocacy when applicable

Contract with community-based navigation and advocacy organization

10) Please share any other general advice or suggestions you may have about behavioral health integration.

It is not realistic to say that our health care delivery system at present includes integrated behavioral health when systems still push clients back and forth secondary to a diagnosis or varying levels of complex health care management.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

A bridge amongst service delivery that is ecological model based, seamless and equitable, including systemic barrier navigation and advocacy and is universally understood but flexibly implemented to meet the client needs.

b. How should RCCOs prioritize who receives care coordination first?

Previous gap analysis of client health outcomes, level of complexity and acute needs

c. How should RCCOs identify clients and families who need care coordination?

Previous evaluation of client health outcomes, level of complexity and acute needs

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

Client experience and health outcomes data

12) What services should be coordinated and are there services that should not be a part of care coordination?

Any service that has an impact on day-to-day health outcomes. Transition and medication management are huge issues. In fact, contemporary care coordination in the perspective of Family Voices Colorado includes systemic navigation and advocacy.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

Previous health history; most impactful social determinants of health; present systemic barriers

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

There are different forms and varying quality of care coordination going on today. Care coordination is can look vastly different in the community versus as part of a system, i.e. hospital setting. Care coordination has

continued to live in silos, often divided even by service and specialty, e.g. neurology, oncology, evaluation. At best, care coordination revolves around "treat and street" mentality, which is medical model based. Traditional care coordination doesn't have an understanding of social determinants or systemic barriers experienced by the patient/client.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

There is agency-specific, system-specific and disability-specific care coordination. Care coordination can go unreimbursed outside of the RCCO/ACC. That care coordination as well as RCCO/ACC does not include systemic navigation or robust advocacy as provided by Family Voices Colorado.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

By setting the tone for higher quality care coordination that includes modernizing by including expert systemic navigation and robust advocacy, the ACC neither duplicates nor disrupts current relationships. This could be accomplished by new partnerships with community-based organizations such as, Family Voices Colorado.

d. What are the gaps in care coordination across the continuum of care?

Poor rapid-response to health changes; lack of historical and/or contextual understanding of health outcomes; no real transition or provider preparedness; no seamless communication among providers; lack of awareness of social determinants; low accountability of information sharing.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	✓	☐	✓	Grievance and accountability
Affordability (assistance with prescriptions or co-pays)	✓	☐	✓	
Daycare / childcare	✓	☐	✓	Program evaluation
Economic stability & employment	✓	☐	✓	
Education	✓	☐	✓	School-based health; service implementation
Environment	✓	☐	✓	Health and safety
Food access / nutrition	✓	☐	✓	Support
Health literacy	✓	☐	✓	Synergy with hospital health education
Housing	✓	☐	✓	Communication with Division
Language or translation services	✓	☐	✓	Assuring accessibility
Literacy	☐	✓	☐	
Transportation	✓	☐	✓	Accountability of providers
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	✓	☐	Supervision; Health education; outcomes evaluation
Certified Addiction Councilors	✓	☐	Counseling; Cross system collaboration
Certified Nurse Midwives	✓	☐	Screening; Supervision; Health education; outcomes evaluation
Community Health Workers	✓	☐	System education through I&R
Generalists (BA/BS/MA/MS)	✓	☐	Task tracking; data gathering
Health Coaches	✓	☐	Health literacy and education; outcomes evaluation
Licensed Clinical Social Workers	✓	☐	Screening; resources; policy; advocacy; provider consult
Licensed Marriage and Family Therapist	✓	☐	Therapy; cross system collaboration
Licensed Mental Health Counselors	✓	☐	Therapy; cross system collaboration
Licensed Professional Counselor	✓	☐	Therapy; cross system collaboration
Masters of Public Health	✓	☐	Policy; Implementation
Medical Doctors / Doctors of Osteopathic Medicine	✓	☐	Screening; direct service; med mgmnt; letters of med nec
Nurse Practitioners	✓	☐	Screening; direct service; med mgmnt; letters of med nec
Patient Navigators	✓	☐	Systems navigation; advocacy; policy; provider consult
Peer Advocates	✓	☐	Training; advocacy
Promotoras	✓	☐	System education and I&R
Psychiatrists	✓	☐	Screening; direct service; med mgmnt; letters of med nec
Psychologists	✓	☐	Screening; direct service; letters of med nec
Registered Nurses	✓	☐	Health education; cross system collaboration
Social Workers	✓	☐	Screening; resources; policy; advocacy; provider consult
Wraparound facilitators	✓	☐	System education, training

Other	Please type your response here.

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	✓	☐	PCP-specialty collaboration; evaluation and service delivery ie EI
Children	☐	✓	
Children who are healthy, but in socially-complex environments	✓	☐	Ongoing evaluation of social determinants; barrier assessment; CWH and navigation; family systems education and advocacy as needed
Children involved in the foster care system	✓	☐	Case management interface cross systemically as well as with PCP
Children with a chronic illness	✓	☐	PCP-specialty-ancillary providers collaboration; barrier assessment; CWH and navigation; family systems education and advocacy as needed
Children with a serious emotional disturbance	✓	☐	PCP-specialty-ancillary providers collaboration; barrier assessment; CWH and navigation; family systems education and advocacy as needed
Children with medical complexity	✓	☐	PCP-specialty-ancillary providers collaboration; barrier assessment; CWH and navigation; family systems education and advocacy as needed
Children or youth with a behavioral health diagnosis or substance use disorder	✓	☐	PCP-specialty-ancillary providers collaboration; barrier assessment; CWH and navigation; family systems education and advocacy as needed
Transition-age adolescents	✓		Provider network adequacy; clearer process especially amongst behavioral health and physical health
Parents and families	☐	✓	
Pregnant women		✓	
Adults	☐	✓	
Adults who are healthy, but in socially-complex situations	✓	☐	Evaluation of health outcomes secondary to social determinants
Adults with a chronic illness	✓	☐	PCP-specialty-ancillary providers collaboration; barrier assessment; CWH and navigation; family systems education and advocacy as needed

Adults with a behavioral health diagnosis or substance use disorder	✓	☐	PCP-specialty-ancillary providers collaboration; barrier assessment; CWH and navigation; family systems education and advocacy as needed
Clients involved in the criminal justice system	✓	☐	barrier assessment; CWH and navigation; family systems education and advocacy as needed
Clients with a disability	✓	☐	PCP-specialty-ancillary providers collaboration; barrier assessment; CWH and navigation; family systems education and advocacy as needed
Clients in a nursing facility	✓	☐	Community living asap; systems education and advocacy as needed
Elderly clients	✓	☐	PCP-specialty-ancillary providers collaboration; barrier assessment; CWH and navigation; family systems education and advocacy as needed
Frail elderly clients	✓	☐	PCP-specialty-ancillary providers collaboration; barrier assessment; CWH and navigation; family systems education and advocacy as needed
Clients in palliative care	☐	✓	
Other populations, please comment: Refugee and undocumented populations need systems education, resources and advocacy funneled through community-based organizations as part of service delivery team.			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

Collaborate through contract for intentional navigation and advocacy fed by intake of RCCO.

19) How should care coordination be evaluated? How should its outcomes be measured?

Improvement in health and systems knowledge as indicated by client experience and engagement; decrease in frequency, duration, complexity of barriers; increase in undisturbed service; expansion of real choice.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

Much higher than that especially in considering varying degrees of complexity and time it takes to provide navigation and advocacy. Traditional care coordination ends at the door and does not bridge gap of systems barriers.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

Yes tiered PMPM would be ideal if for complexity not necessarily population versus population. A cost similar to service delivery rates such as HH, day program; and should include consumer direction as appropriate.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

A manageable ratio would be helpful. It should vary by acuity, complexity of barrier and expertise of worker.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	✓
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

Improvement in health and systems knowledge as indicated by client experience and engagement; decrease in frequency, duration, complexity of barriers; increase in undisturbed service; expansion of real choice.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

As aforementioned it needs to be modernized to beyond discharge-like practices to include systemic navigation and advocacy and include more consumer direction.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Care coordination; transition; data reporting; accountability; meaningful grievance; due process

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Proven ability to access clients; meaningful partnerships; person centric and inclusiveness practices

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

Effective if based on client choice and fit

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes, to expand choice and options and to reposition rural areas that have been underserved.

28) Should the BHO region maps change? Why or why not? If so, how?

Yes, to expand choice and options. How should be based on client experience and issues with service delivery.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

Align rules from different departments that involve service delivery and oversight of care coordination

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

Only if current client experience is poor; choice without options is not real choice.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

Initial referral and follow up on connection.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

Rules/regs; Provider accountability

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

Rules/regs; Provider accountability

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

Access

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Rules and regs; due process

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

Key-informant status; meaningful ways to drive resolution policy decisions.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

Monthly convenings and proactive information gathering used for quality improvement

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

Contracts for specific actions/tasks

42) How should the Department structure stakeholder engagement for the ACC as a whole?

As key-informant and a driver of program improvement

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

No

a. If no, what are the gaps?

Knowledge of systems and how to provide care for complexity

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

Lack of understanding of how to provide care; manage social determinants of health; willing administration

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

Care coordination; billing; barrier resolution

b. What role should pharmacies play in the next iteration of the ACC Program?

Barrier resolution

c. What role should specialists play in the next iteration of the ACC Program?

Authorization

d. What role should home health play in the next iteration of the ACC Program?

Improved service delivery

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

Conflict free practices and more robust understanding of all options and services related to clients,

g. What role should counties play in the next iteration of the ACC Program?

Improved eligibility and information of systems

h. What role should local public health agencies play in the next iteration of the ACC Program?

Care coordination and resources

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

Navigation and advocacy contractors. Yes there are valuable assets in the community. Family Voices Colorado is only one example.

45) How can RCCOs help to support clients and families in making and keeping appointments?

CHW

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

Yes as well as experts in complex barriers and direct advocacy

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	✓
On staff (salary) at Primary Care Medical Provider Clinic	✓
On staff (salary) at RCCO	✓
Per Member Per Month Payment	✓

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

An ongoing level of understanding and knowledge that requires responsive and inclusive practices.

b. What RCCO requirements would ensure cultural competency?

Continued education and training; client interactions

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

Intentional interviewing and access to experts in the community of the clients

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Meaningful engagement with the community

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

Only if it doesn't decrease service delivery.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Assure access, choice and direction to clients and families

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	✓	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	✓	☐	
Patient Activation Measure	✓	☐	
Focus groups	✓	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type**. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	✓	☐
Care management tool	☐	☐	☐	☐	✓
Care transitions alerts	☐	☐	☐	☐	✓
Electronic Health Records (EHRs)	☐	☐	☐	☐	✓
Practice assessment tools	☐	☐	☐	✓	☐
Health risk assessment software	☐	☐	☐	☐	✓
Practice management tools (scheduling, billing)	☐	☐	☐	✓	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	✓
Patient education wellness tools	☐	☐	☐	☐	✓
Provider/case manager directory	☐	☐	☐	✓	☐
Shared decision-making tools	☐	☐	☐	☐	✓
Telemedicine	☐	☐	☐	☐	✓
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Cost, TA, management, timely entry and analysis, cross-system interoperability.

81) How can Health Information Technology support Behavioral Health Integration?

Coordination could actually be seamless.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

Health outcomes data and social determinants. Previous barrier to care list.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

Supporting interoperability.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

PHR owned by client.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 081

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Allison Cusick
Location: Denver, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Delta Dental of Colorado and Delta Dental of Colorado Foundation
Location: Denver, Colorado
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☒ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Dental Insurance Carrier

Are you currently involved in the ACC program?

☐ Yes
☒ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Very limited.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Our mission is to improve the oral health of the communities we serve.

We are currently not involved directly in the provision of Medicaid yet through our community benefit and Foundation programs, we aim to 1) increase access to oral health care for the underserved, many of whom are enrolled in Medicaid and CHP+, and 2) increase the public's awareness regarding the importance of oral health.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☒ N/A

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

2) What is not working well in the ACC Program?

Oral health is not included as part of the ACC program model. If the state wants to be truly comprehensive in serving "all aspects of a person's health care," dental must be a part of the ACC program model.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

National Quality Farum: *Core coordination is o function thot helps ensure that the potient's needs and preferences for health services and informatian shoring ocrass people, functions, ond sites ore met aver time. Coardination moximized the value af services delivered to patients by facilitating beneficiol, efficient, sofe, and high-quolity patient experiences and impraved healthcore autcames.*

b. How should RCCOs prioritize who receives care coordination first?

The National Quality Forum also notes that care coordination is "especially important for people with chronic conditions, such as diabetes..." Individuals with chronic conditions place a significant burden on the overall healthcare system, including medical, dental, and behavioral health, and by coordinating their care may help reduce costs and improve outcomes.

It is also vital to coordinate care for Medicaid families with children who may not be familiar with navigating the healthcare system. There are many barriers to accessing care, and care coordination could alleviate some of these barriers. Additionally, there is great opportunity to ensure that children remain as healthy as possible, with oral, behavioral, and overall health, if they have access to coordinated services aimed at prevention and early intervention.

c. How should RCCOs identify clients and families who need care coordination?

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

Services related to an individual's overall health and well-being should be coordinated. This includes, but is not limited to medical, behavioral, and oral health.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☒	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☒	☐	☐	
Health literacy	☒	☐	☐	
Housing	☐	☐	☐	

Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	
Transportation	☐	☐	☐	
Other	It appears that you're not considering dental when you refer to "health care". While we believe the oral health is an integral and natural part of healthcare, we are specifically calling it out here, because if you're truly going to provide comprehensive care coordination, oral health cannot be left out.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	
Certified Addiction Councilors	☒	☐	
Certified Nurse Midwives	☒	☐	
Community Health Workers	☒	☐	
Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☒	☐	
Licensed Mental Health Counselors	☒	☐	
Licensed Professional Counselor	☒	☐	
Masters of Public Health	☒	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	
Nurse Practitioners	☒	☐	

Patient Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☒	☐	
Psychiatrists	☒	☐	
Psychologists	☒	☐	
Registered Nurses	☒	☐	
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	
Other	Dental Professionals – Dental professionals must be recognized as an part of an integrated health care team. Dentists and dental hygienists can provide reminders and support the coordination of regular and/or follow-up care for patients with chronic conditions such as heart disease, diabetes and for pregnant women.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	

Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐

201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

It is difficult to tell how dental providers are currently a part of the ACC model. That said there are currently not enough dental providers to adequately serve the ACC population. Dental providers that accept Medicaid are often in the center of urban areas, leaving large access gaps in more rural areas.

a. If no, what are the gaps?

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

There could be potential partnerships with Foundations to leverage and/or spread innovative models of care to the ACC model. This may include such projects as Delta Dental of Colorado Foundation's Medical-Dental Integration project, which aims to co-locate dental hygienists as part of the medical care team to provide preventive dental services. There may also be opportunities to pilot smaller projects in collaboration with Foundations and/or other non-profit organizations.

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

Yes. These individuals play a key role in educating families, coordinating and case managing care, and assisting families with understanding how to navigate the entire health system.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

Dental care is an important benefit for individuals and should be integrated into the RCCO structure. Delta Dental of Colorado administers the CHP+ program for the state, and has gained a level of understanding of what is needed to successfully administer this type of program. To attract and retain a high quality, robust dental network it is imperative that there is 1) a good plan design, 2) competitive dental fee reimbursement structure, and 3) broad access to care. Improving access to and utilization of preventive dental care, will reduce the need for more costly restorative services and emergency room utilization.

A dental carrier with a strong network within Colorado should be contracted with to administer the dental benefit, conduct member outreach, develop a strong network, and work with other RCCO partners to ensure maximum medical-dental integration. RCCO's can support the dental carrier by ensuring that members utilize their dental benefit at a dental home. This is especially important for at risk populations such as children, pregnant women and older adults with chronic conditions such as diabetes and heart disease.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

   a. What does cultural competence mean to you?

   b. What RCCO requirements would ensure cultural competency?

   c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

   d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Dental providers and organizations are a critical partner to reducing emergency room utilization. Through partnerships and care coordination, children and adults will have greater access to prevention and early intervention for their dental needs. This will reduce higher cost restorative procedures and emergency

department utilization. We encourage the ACC to ensure that the RCCOs include dental providers in their network of providers and include an oral health access measure in their reporting.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 082

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

GENERAL QUESTIONS

1) What is working best in the Accountable Care Collaborative (ACC) right now?

The present arrangement promotes local service delivery and effective care coordination, and it decelerates cost increases. This investment into the community and local coordination enables us to meet local needs. The promising cost containment opportunities through the ACC helps promote successful integrated health care.

Working with the ACC allows the Regional Care Collaborative Organizations (RCCO) to work independently and meet contract requirements. This level of autonomy allows RCCOs to be creative as they strive for solutions, which translates into greater innovation.

2) What is not working well in the ACC Program?

Reducing the cost of care requires program innovation. At present, there is too much of a singular focus on care coordination instead of concentrating on additional systems and solutions that meet all elements of the Triple Aim. Efforts must be made to better align incentives for reform. In the current model, true payment reform is not possible. Each RCCO's expectations align with their contracts with other entities and agencies; however, the State holds the contracts with providers rather than the RCCOs. The RCCOs therefore cannot provide incentives or engage in payment reform at the point of care.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

By increasing the implementation of integrated care models, the BHO system has achieved significant progress in reaching the Triple Aim goals of improving client experience and improving health outcomes in a cost-effective manner. Joint BHO/RCCO partnership efforts and other community-based initiatives also contribute appreciably to obtaining these goals.

The current BHO system has also successfully slowed cost increases. Based on an evaluation of 15 years of data completed by the Altarum Institute (2011), the Colorado behavioral health carve-out model has slowed cost growth while increasing service access and maintaining quality.

The maturity of the BHO system enables the BHOs to quickly implement benefits for new populations. BHO performance has steadily improved, which is evident through a variety of validated performance indicators, such as:

- Flexible and sophisticated encounter/claims systems

- High compliance with contract, State and federal standards, as demonstrated through the EQRO compliance and performance measure validation reviews

4) What is not working well in the BHO system?

Our first priority is to provide the most efficient care for the individuals we serve, but the "silo" design of the current BHO system splits an individual into separate diagnoses (e.g., separate diagnoses within the DD and SUD systems). This process creates a disparity of care, as the more silos are created the more barriers are created toward true care integration. Our suggested improvements will be found in questions 7 to 18 of this response.

5) What is working well with RCCO and BHO collaboration right now?

The strong RCCO and BHO collaboration has increased care coordination, which is an important first step. The collaboration has created the opportunity for personnel from both of these entities to work together. Such teamwork incites innovation.

6) What is not working well with RCCO and BHO collaboration right now?

Though payment reform is in progress, it is occurring at too slow of a pace to impact true health reform. For the future, the models should be based on joint accountability and true integration supported by payment reform initiatives.

BEHAVIORAL HEALTH INTEGRATION

7) What should be the next steps in behavioral health integration in Colorado?

The next steps in behavioral health integration within the RCCO model should move beyond a fee-for-service delivery model between disparate healthcare systems to one that includes care coordination, enhancements of all providers' holistic approach to care, and models of payment reform such as global payment, payments for episodic care, and/or capitation/sub-capitation. While care coordination increases access to health care services for people identified as needing care coordination, it does not ensure improvement in individual clinical outcomes at the point of care. We suggest the following as immediate next steps:

1. Conduct a comprehensive analysis to identify and remove barriers to payment reform. Although payment reform in and of itself will not produce practice transformation, financial sustainability is a significant consideration for most practices.

   Analysis could include:

   - What State and Federal rules, regulations, policies, and procedures restrict or impede the delivery and reimbursement of integrated care? (i.e., same day billing restrictions, pre-certifications, prior authorizations, etc.)
   - What primary care and behavioral health services are eligible for encounter rates?
   - What behavioral health services still require CCARs and pre-authorizations, and how can these requirements be modified in order to facilitate integrated care delivery?
   - What integrated behavioral health services fall under capltation or case rates, where used?

2. Conduct a comprehensive analysis to identify and remove communication barriers between behavioral health and medical providers. Confusion regarding HIPAA and CFR42 regulations poses major challenges to integrated care delivery, regardless of whether the model of care is co-located or through collaborative agreements between behavioral health and medical providers.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

While definitions of integrated care vary, most rest on the premise of care that includes attention to a person's medical, behavioral (including substance use), and psychosocial needs. However, it is important to differentiate between care that occurs in a coordinated fashion across different settings and care that is delivered in the same setting. At minimum, integrated care in Colorado should be co-located, meaning that behavioral health and medical providers are practicing in the

same physical location. While co-location alone does not ensure whole-person, whole-family integrated care, it is a necessary component. Features that demonstrate practice transformation include open communication between providers (including documentation), purposeful use of universal standardized screening, treatment plans that include medical and behavioral data, and monitoring of health and behavior change rather than concentrating solely on mental illness.

10) Please share any other general advice or suggestions you may have about behavioral health integration?

We make the following additional suggestions about behavioral health integration:

- **Integration takes time**: Integration is a multivariate, multi-systemic endeavor that takes time to accomplish. It follows a developmental trajectory of trial and error and cultural transformation that can take several years to mature. Because few practices currently operate at a high degree of integration, practices that are starting to head in this direction should be allowed a reasonable timeframe to reach full integration.

- **There are many ways to accomplish integration**: Because clinics respond to the needs of their specific populations and work within financial and human resource realities, clinics vary greatly in terms of staffing, workflows, protocols, and treatment approaches.

- **Integrated care alone does not ensure whole-person care**: Integrated care is primarily focused on the outpatient level of care at both the medical and behavioral levels. However, there is still a need for coordination with specialty services, and that includes the current mental health system responsible for managing the needs of the severely and persistently mentally ill. Additionally, holistic care for Medicaid recipients requires that their other psychosocial needs are also addressed. Basic needs such as housing, food, and safety must be met if there is any hope for improved health outcomes. Coordination with other service systems such as Housing Authorities, TANF/WIC, Foster Care and Juvenile Justice Systems, Corrections, and the myriad of non-profit organizations that support these individuals should be a required component of person-centered care planning.

- **Integrated care should not be setting specific**: All people, regardless of their level of need, can benefit from an integrated approach. While these needs can be managed in high-quality integrated primary care settings for the majority of the population, it is equally important to meet the medical needs of people who are active users of the mental health system.

CARE COORDINATION

11a) Care coordination is an important part of the ACC Program. What is the best definition of care coordination?

With reference to a definition developed by the Agency for Healthcare Research and Quality (AHRQ), ValueOptions utilizes the following modified version:

"Care coordination is the deliberate organization of client-focused care activities between two or more participants (including the client) involved in a client's person-centered care plan. The care coordination process facilitates the delivery of appropriate healthcare services and integration of behavioral and physical healthcare systems. Organizing care involves the marshalling of various personnel and other resources required to carry out all necessary care activities. It is often managed by the documentation and exchange of information among all participants responsible for the different aspects of care."

Activities may include: comprehensive care management, coordination of care among treating providers, health promotion and education, comprehensive support during transitions between levels of care, psychosocial support for the client and the client's caregivers and family, referrals to community resources, and utilization of a consolidated client health record.

11b) How should RCCOs prioritize who receives care coordination first?

RCCOs should prioritize which individuals have access to care coordination services through a combination of data analytics with population stratification and employing real time clinical criteria and algorithms designed to quickly identify and engage clients with emerging risk that have not yet fully registered within the analytic review process. In addition to the data-driven stratification process that identifies highest to lowest risk candidates for care coordination, an assessment process should be applied for all individuals to quantify current coordination needs and recalibrate risk scores for participation.

11c) How should RCCOs identify clients and families who need care coordination?

RCCOs would use a combination of the data-driven analytics and the real time event-driven criteria to identify participants for care coordination activities. Real time events may include major health adverse incidents requiring hospitalization and transitions back to community-based care such as a cardiac event stroke, joint replacement, or psychiatric hospitalization for suicidal ideation. Data-driven identification may include cumulative risk scores based on predictive modeling and significant care gaps requiring coordination for closure.

11d) How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

RCCOs should track care coordination provided by delegated medical providers using a quality and informatics/analytics based oversight process. The RCCO could provide the parameters used to measure the care coordination process to the delegated provider management team. Operational and clinical outcomes reports, as well as quality audits, provide the evidence that these parameters have been met. Sample parameters would include but are not limited to:

- Utilization of a mutually agreed stratification and prioritization process for assigning care coordination resources
- Percentage of clients engaged in care coordination within a year compared to overall population served (engagement defined as successfully contacted, agreement to participate, and completion of an initial needs assessment)
- Percentage of clients engaged in care coordination in relationship to the total number identified and referred.
- Percentage of clients with a comprehensive needs assessment and care plan developed within 30 days of initial identification/referral
- Percentage of clients with hospitalizations, residential treatment, or skilled nursing home rehabilitation receiving care coordination services per recommended protocol while transitioning back to community based care
- Readmission rates within 30 days of clients with hospitalizations, residential treatment, or skilled nursing home rehabilitation transitioning back to community based care
- Clients with chronic health conditions receiving recommended annual interventions per best practice guidelines
- Clients with chronic health conditions requiring medication treatment remaining adherent with medication regimens

12) What services should be coordinated and are there services that should not be a part of care coordination?

Any formal benefit related service, as well as informal services supporting the needs for clients with complex health issues requiring care coordination support, should be included within the scope of care coordination activities. This would also include services that are registered on the plan of care: community based programs, prevention and health promotion, outpatient treatment for behavioral and medical care, long term services and support, rehabilitation, intermediate levels of care, crisis support and interventions, higher levels of care (inpatient, residential, skilled nursing, and rehabilitation), pharmacy services, dental services, and psychosocial support.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

The ultimate goal of care coordination is to support the improvement of health, which includes physical health and recovery from mental illness. The process begins by gathering information obtained through a comprehensive needs assessment and review of available records, conducting direct recovery-focused interviews with the client, and obtaining additional information from the client's care team addressing the following areas:

- Immediate needs and current services
- Historic services received in addition to current services
- Health conditions including both physical and behavioral health (mental health and substance use) and current medications
- Functional status that includes the client's strengths and barriers
- Accessibility requirements (including communication needs, need for transfer equipment, need for personal assistance, need for appointments at a particular time of day)
- Transportation access
- Equipment needs including DME and assistive technology
- Housing/home environment
- Employment status and interest
- Involvement with other care coordinators, care teams, or other state agencies
- Social supports
- Cultural, linguistic, and ethnic identification
- Food security and nutrition
- Wellness and exercise
- Advance directives/guardianship
- Personal goals
- Understanding of available services and benefits
- Understanding of and engagement in recovery-oriented activities

14a) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems. What care coordination is going on today?

We recommend a dedicated primary care coordinator through our delegated provider relationships. When the primary care issues are physical health related, the dedicated primary care coordinator from the Federally Qualified Health Center (FQHC) group would serve as the key contact. For clients with primary care issues associated with behavioral health, the dedicated primary care coordinator from the Community Mental Health Center (CMHC) would provide the service. Clients not attributed with either a CMHC or FQHC would receive a primary care coordinator through the RCCO. In all cases, the overall care coordination needs should be

addressed by the primary care coordinator with collaboration with the other provider entities as needed.

14b) What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

The care coordination process would be provided as outlined in the response to Question 14a above. All care coordination would take place using a RCCO-related care coordinator, either through the RCCO provider partner or through the RCCO care coordination staff. Case management is provided in ancillary systems, such as HCBS programs, child welfare, and juvenile justice. That care management is different because each process is responsible only for the services provided within its system. The RCCO Care Coordination process is not specific to any service system and works to coordinate and align these systems and their respective case management targets to promote a holistic plan of coordinated care.

14c) How can the ACC avoid duplicating or disrupting current care coordination relationships?

Successful care coordination relies upon continuity of relationship and the minimization of duplication and/or disruption of care. A primary care coordinator should be responsible for coordinating all aspects of the client's care needs, relying on consultation with the allied care team and ACC partners as needed for condition-specific questions requiring specialty input. Care coordinators should develop a centralized person-centric care plan based on the individual's needs and distribute this to key participants on the care team. In addition, case managers for services such as Child Welfare and JJA/Correction should also be part of the care team. The primary care coordinator should also schedule interdisciplinary care team meetings including the client to review and adjust the care plan based on progress and setbacks.

14d) What are the gaps in care coordination across the continuum of care?

Delay in sharing rapidly changing health information following key health events is the largest source of care gaps in the continuum of care. For example, a client may receive services in the emergency room. Ideally the care coordinator would receive notification within 24 hours of the visit in order to assess current health needs and make sure they are met. Refining the process of real time data sharing is critical for effective care coordination.

16) Requirements about who should be doing care coordination. Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Our recommendation is to utilize a primary dedicated care coordinator model matching the client's primary needs with the appropriate coordinator who may be on staff with the ACC provider partner or part of the ACC. For this reason, we suggest employing and contracting with multi-disciplinary provider types. We would differentiate provider types that serve as the primary coordinator and those that serve as adjunct or secondary coordinators supporting the primary coordinator, such as a certified peer specialist. Those serving on the client's care team would be expected to collaborate with the coordination process as appropriate to their role.

17) Care coordination requirements for specific populations. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

We would utilize a 'generalist' primary care coordinator as a starting point specific to medical or behavioral health service needs with additional specialty or training when available to further address the unique service needs. We would also employ a consultation model and adjunct coordination supports to further address the unique requirements of these client types.

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

Traditionally, the BHOs have participated in programs that bring together various systems (DHS, juvenile justice, schools, BHOs) to provide coordinated care for high risk families. RCCOs could become involved in these types of coordinated care projects to incorporate medical services. Of particular importance to this population are preventive services such as childhood immunizations, well-child checks, and comprehensive programs that include educational, environmental service, and social support elements for chronic diseases that are drivers of high ER utilization (e.g., pediatric asthma).

RCCOs should also collaborate with the courts, probation, schools, and other treatment providers to keep children out of residential placement through the juvenile justice system. RCCOs should also participate in the DHS Core Services program and with specialty programs such as The Collaborative for Autism and Neurodevelopmental Disabilities Options, and the Reduce, Educate, Accommodate & Pace program (for Traumatic Brain Injury in children).

PROGRAM STRUCTURE

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Where feasible, standardized functions provide consistency of care and facilitate quality reporting. However, regional variation in resource availability and population demographics often poses barriers to effective standardization. Provider contracting and payment methodologies should remain flexible functions in order promote creative solutions across regions. High-level uniform functions should be required in order to generate meaningful data aimed at ensuring consistency of care for specific cohorts. Specifically, care coordination functions should follow clinically-relevant, best practice continuity of care standards, and reporting requirements should be based on preventive and acute care measures that align with parallel initiatives such as PCMH recognition, Stage 1 Meaningful Use, and CMS Core Measures.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Bidders should be required to have a local presence to assure a point of accountability with an understanding of the community and its strengths in order to ensure opportunity for collaboration. Upon contract implementation, bidders should be required to perform a needs assessment and to update it annually.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

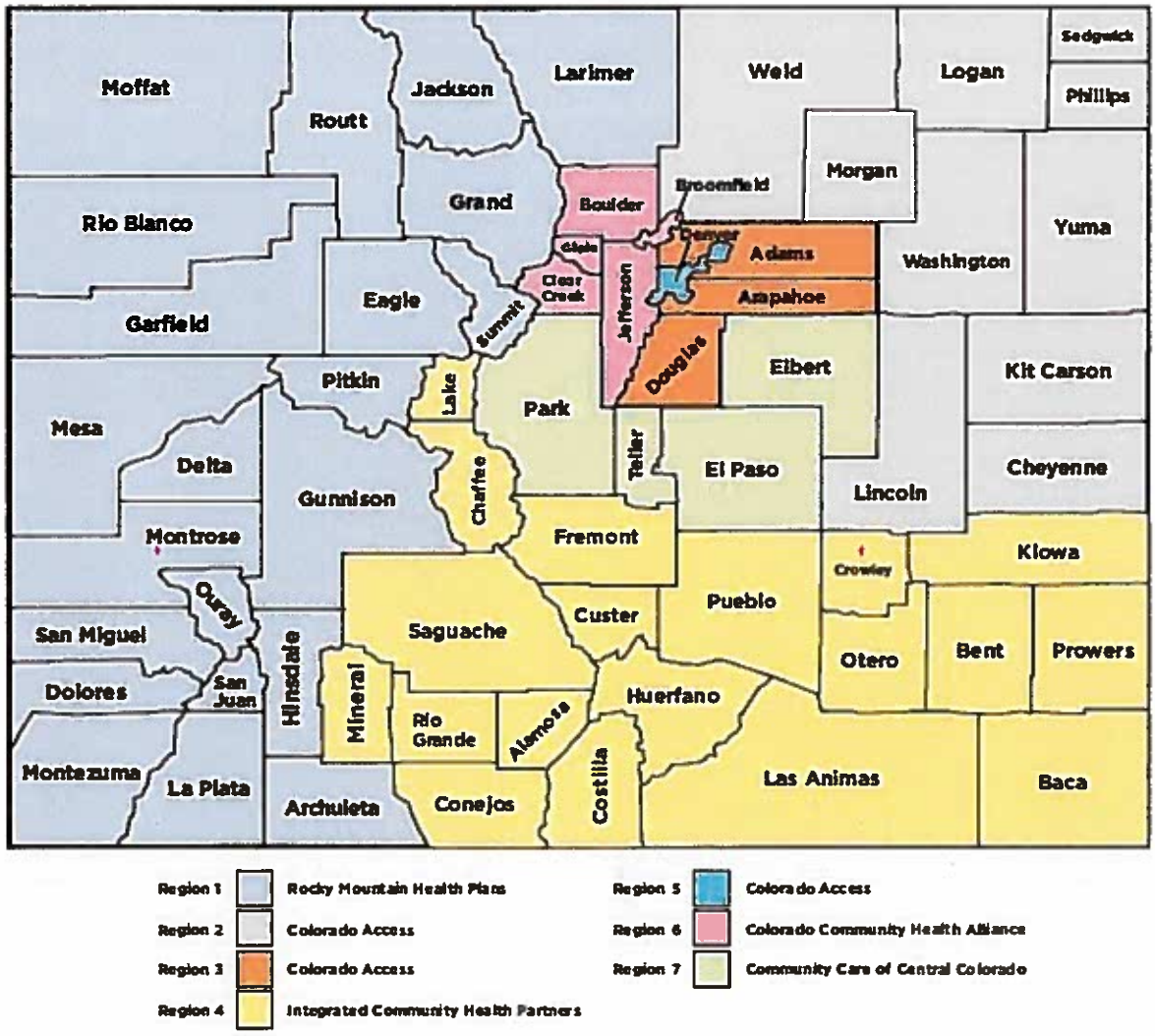
28) Should the BHO region maps change? Why or why not? If so, how?

Allowing PCMPs to choose the RCCO to which the practice's clients are enrolled may have marginal success as there would need to be multiple RCCOs in one region. However, in regions such as the Denver metro area, choice and competition would be highly valuable, when logistics

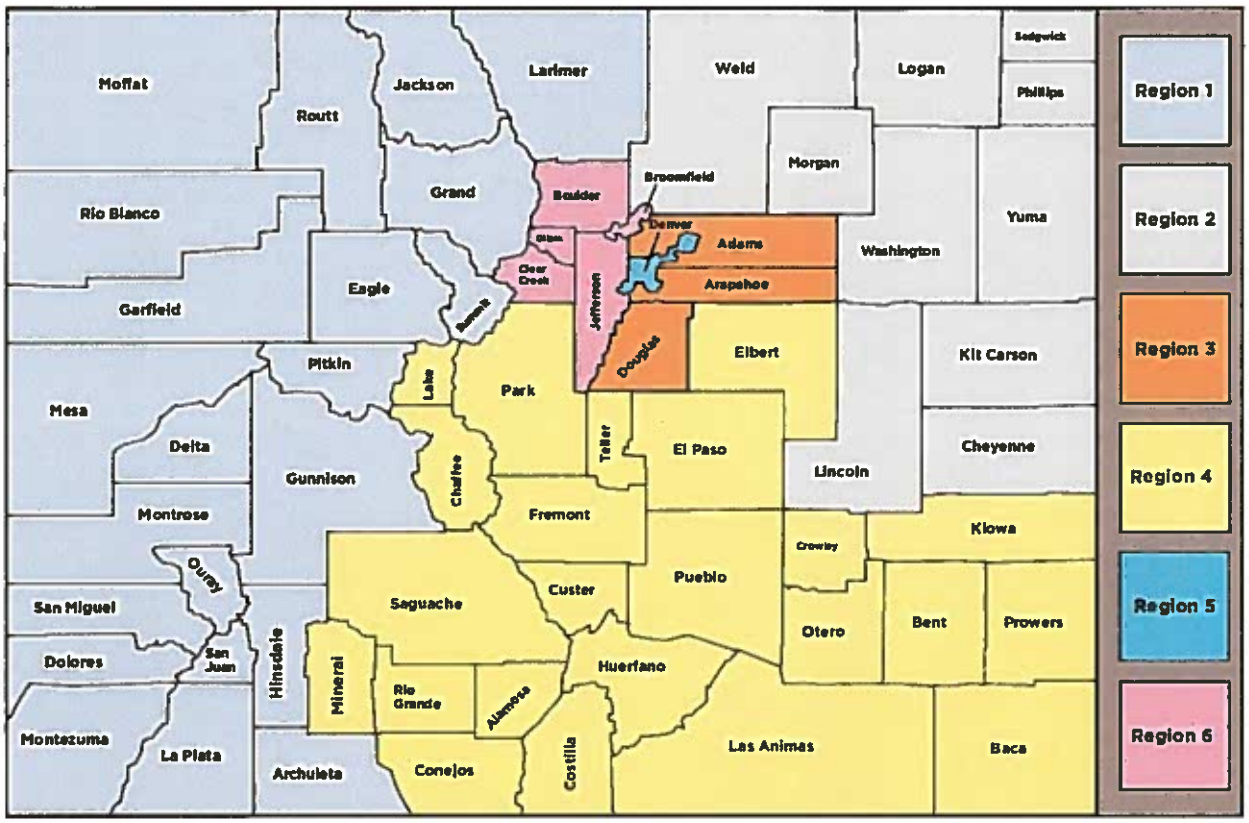
permit. If this choice option is initiated, individual choice would likely be preferred over provider choice.

The RCCO map should change to more closely align natural support systems. For example, Pueblo and Colorado Springs regions should be one region. This would align more closely with the BHO regions and require fewer RCCO regions. Please refer to the map below for a possible reconfiguration of the regions.

CURRENT MAP OF THE COLORADO REGIONS



MAP OF COLORADO FEATURING RECONFIGURED REGIONS



29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

ValueOptions would suggest a transition period of at least six months. This would ensure that proper transition and implementation processes are in place to safeguard the continuity and quality of care that clients receive, avoid disruption and/or transition noise, and mitigate transition risk throughout the RCCO region.

The core activities that occur during the transition period include, but should not be limited to:

- Identifying a local presence in the RCCO region
- Hiring and training of staff
- Developing working knowledge of local services and resources
- Developing protocols and procedures
- Initiating and developing provider contracts
- Ensuring continuity of care for individuals receiving services

- Conducting outreach and education for individuals, families, providers, and other organizations
- Any IT build out or data management preparation

The expenses involved in the transition will vary.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

Multiple RCCOs could enhance individual choice, but reporting and eligibility issues could arise from a multiple RCCO structure. This would not be possible in most regions; however, it may be an important change for the Denver metro area.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

RCCOs should have administrative responsibilities for attributions within defined guidelines.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

The success of any program stems from integrated and collaborative efforts with State agencies and departments. That is why we strongly support the involvement of all stakeholders within a transparent environment. In many of our public/private partnerships, we have developed a "knowledge exchange" philosophy that guides our approach to implementing successful programs. Our knowledge exchange philosophy proposes that no one individual or organization possesses all knowledge, and that everyone involved has something to gain from an open, honest exchange of information. We assert that all individuals who have a stake in an initiative, from a strategic level to those administering hands-on care for the individuals we serve, have something to offer and that all stakeholders can learn from each other. This is the philosophy that we would suggest in order to effectively collaborate with the Colorado Departments of Health Services and Public Health and Environment, the Department of Regulatory Agencies or the Division of Insurance, Connect for Health Colorado, and the greater insurance marketplace. Our experience has shown that the synergy produced by mutual learning helps to create a program that is effective at the outset and that will continue to progress as the relationships develop.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

Please see our response to question 35 above.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

Please see our response to question 35 above.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Please see our response to question 35 above.

NETWORK ADEQUACY AND CREATING A COMPREHENSIVE SYSTEM OF CARE

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

The current network does not adequately serve the ACC population.

43a) If no, what are the gaps?

Below are the gaps in service for the ACC population.

- Specialty services (Neurology, Dental, Orthopedics) for Medicaid includes long wait times for appointments
- Transportation to and from services (food banks, medical appointments, DHS offices) is inadequate
- Access to services for children is a critical gap. Every child should have the opportunity to receive services that others have access to. The current silos by which services are delivered impede whole-person, whole-family integrated care.

45) How can RCCOs help to support clients and families in making and keeping appointments?

There are many technological programs and services at the RCCOs' disposal to assist individuals in making and keeping appointments. Provider education will also help to educate and empower consumers.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

Community Health Workers and Patient Navigators with state-recognized certification should be required as part of the next RFP.

47) Community Health Worker reimbursement. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	
On staff (salary) at Primary Care Medical Provider Clinic	✓
On staff (salary) at RCCO	✓
Per Member Per Month Payment	

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

Culture influences all aspects of human behavior, including health maintenance behaviors and how health beliefs and practices are passed from generation to generation. Recovery, rehabilitation, and reintegration are more likely where systems and services are created with cultural sensitivity in mind, and when providers have the cultural competence needed to understand the backgrounds of the families and communities they serve.

This objective not only addresses the needs of individuals served, but also takes into consideration all underlying social and institutional inequalities that lead to low health literacy. Disability and poor health goes beyond the individual's health status; environmental barriers such as racism and poverty influence his or her recovery and access to care. Cultural competence acknowledges and incorporates an appreciation of diversity and an acceptance of various behaviors, beliefs, and values when providing services and includes those variables into the assessment and treatment of the person.

The mission of the National Center for Cultural Competence (NCCC) informs our approach to cultural competence. NCCC tenets that serve as the foundation of our own practices are the following:

- We are committed to broadening multi-cultural participation in our provider network.
- The organization must value diversity
- The organization should have a way to conduct a self-assessment.
- The organization should have administrative structures that enable them to manage diversity, such as policies, procedures, and training that address diversity.
- The organization should have a plan to acquire and incorporate cultural knowledge.
- The organization should have a way to identify and to adapt to the culturally diverse communities they serve.

49) c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

In order for providers and staff to provide culturally and linguistically responsive care, we must establish policies and procedures that ensure that all organizational and individual activities are culturally competent. Our staff and network providers are trained to respect the cultural differences of the individuals we serve and provide care that is imbued with the understanding and appreciation of these differences in order to improve the overall health literacy of the community.

We are committed to breaking down the barriers to access and utilization that many minorities face when accessing health care. These barriers include relevancy of services, financial, language and literacy barriers.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

Yes, the next RFP should allow for networks other than the State's Medicaid providers.

PRACTICE SUPPORT

53) Support for practices. Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

TYPES OF SUPPORT

Tools	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support		✓		
Network provider education	✓			
Assistance with practice redesign	✓			
Assistance with efficiency-enhancing activities	✓			
Provide web-based resources and directories	✓			
Provide practice-specific data reports	✓			
Provide clinical care guidelines and best practices	✓			
Provide clinical screening tools	✓			
Provide health and functioning questionnaires	✓			
Provide chronic care templates	✓			
Provide registries	✓			
Offer client reminders	✓			
Offer client self-management tools	✓			
Offer educational materials about specific conditions	✓			
Supply behavioral health surveys	✓			
Supply other self-screening tools	✓			
Administer behavioral health surveys	✓			
Administer other self-screening tools	✓			
Prepare client action plans	✓			
Provide training on providing culturally-competent care	✓			
Provide training to supporting staff	✓			
Provide training on motivational interviewing	✓			
Provide tools and software for phone call and appointment tracking	✓			
Provide tools and resources for tracking labs, referrals, etc.	✓			
Provide referral and transitions of care checklists	✓			
Provide visit agendas or templates	✓			

(This table is continued on the next page.)

Provide comprehensive directory of community resources	✓			
Provide directory of other resources	✓			
Provide materials regarding Nurse Advice Line		✓		
Ensure all tools and resources are centrally located on RCCO-specific website	✓			

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

The most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home is a risk-adjusted per member per month payment for a defined set of primary care and behavioral health services combined with a quality incentive payment methodology to reward quality measurement and high-quality care.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

Yes, the department should require that PCMPs utilize disease registries to manage the health of their population:

- **State Level Registries**: Publicly available data should be used to inform population health management. Examples include the Central Cancer Registry, the Birth Defects Registry, the multi-state Autism and Developmental Disabilities Monitoring Network, the Immunization Information System, and Colorado Health Information Dataset.
- **Point of Care Registries**: These should be accessible by the entire treatment team, include medical and behavioral health, and be tailored to a practice needs and its client population. In addition to disease registries, prevention-oriented registries should be included for recommended services by age and gender. Ideally, registries should be up-to-date, searchable by field, and capable of being used to identify care gaps to inform care coordination.

PAYMENT STRUCTURE AND QUALITY MONITORING

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

The current payment structure meets the goals of the ACC; however, as the program grows efforts must be made to allow for alternative payment structures and payment reform to motivate providers to give the highest quality care that yields positive outcomes.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

In the current environment, providers may not have the infrastructure to tie payments to value. However, it should be incumbent upon the RCCOs to support the necessary technology and provider support systems to providers to achieve the alignment between quality care and payment.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

We believe that appropriate security is necessary for RCCO contracts. A requirement for LSLPN or HMO licensure or a financial reserve requirement similar to those under LSLPN or HMO licensure will not preclude ValueOptions from bidding.

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

The RCCOs should play a key role in payment to providers, and providers' incentives for quality care should be aligned with a RCCO payment mechanism. Payment should be reformed to allow RCCOs to motivate providers to give the highest quality care that yield positive outcomes with incentives.

66) Measuring Client experience. Please complete the table below to indicate how the Department should measure Client/patient experience:

Should this Tool be used?	Yes	No	Comment
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	✓		
SF-12 Health Survey	✓		
Other types of client interviews / surveys	✓		
Patient Activation Measure	✓		
Focus groups	✓		
Other	Answer:		

We support best practice outcomes for each category. RCCOS should be responsible for surveying clients and collecting the outcomes data, and then adopting the tools that produced the strongest results as best practices.

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

Although claims are useful for measuring population health, claims alone do not tell the whole story. Claims do not contain clinical information such as vital signs, lab values, and the full diagnostic picture. This information is critical for proactive management of high-risk clients. Moreover, claims do not always capture all services rendered at the point of care. For example, it is not possible to tell from a claim if a client recently discharged from a hospital for cardiac event has been screened for depression. Although a system capable of integrating the full array of EHRs with claims may not be feasible, it would be possible to build a reporting structure consisting of key EHR fields that could be analyzed in conjunction with claims.

Other population health metrics could include life expectancy from birth, or age-adjusted mortality rate, condition-specific changes in life expectancy, or condition-specific or age-specific mortality rates, self-reported level of health or functional status, and experiential status.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

External dashboards with a high level of transparency should be implemented to best report quality and performance data to the RCCOs, PCMPs, and the public. Data should meet both HEDIS® performance measures to provide nationally comparable outcomes information to gauge program effectiveness, as well as local metrics.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	✓
8-10	
11-20	
21-30	
31-40	
41-50	
51+	
None	

This will increase as providers gain reporting infrastructure with support of the RCCOs.

70) What percent of RCCO payments should be tied to measures or performance?

The RCCO should be allowed to accept a global capitation if their program can accommodate such a model. Also, a Medical Loss Ratio should be developed by which gain-sharing or partial risk corridors can be established. Under these models, a margin of 3 percent should be at risk with an established MLR and administrative fee. Any incentive payments should be directly linked to outcomes.

(Please see the table below.)

*HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Percentage	
10-20%	✓
21-30%	
31-40%	
41-50%	
51-60%	
61-70%	
71-80%	
81-90%	
91%+	

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

The RCCOs need core KPIs that promote the kind of advancement needed to provide the best care for the individuals we serve. All RCCOs should be held accountable for their results as they relate to quality and outcomes. This also allows for comparison in performance and an opportunity to learn when variation exists. Outside of those core KPIs, RCCOs should be assigned other KPIs based on their current performance. These KPIs will be individualized to the RCCO's status in terms of programmatic and financial transformation. These additional KPIs should be assigned strategically to yield the best provider outcomes. Such individualization will promote the innovation needed to improve the entire system, and unique approaches that emerge should be adopted later as best practices. Providers must assure attainment outcomes for these additional KPIs, and we will support their efforts through consultation and learning collaborations.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

National standards should be used to inform baseline KPIs. However, it is also important to incentivize improvement, particularly for providers who start out from poorer baselines, or who have a high number of complex clients or other disparities that could impact performance—large disparities in very small populations have a different impact than similar disparities in larger populations. RCCOs should be allowed flexibility in determining additional incentives based on improvement, as there will be regional variables that will be need to be considered. One suggestion is to offer PCMPs a menu of process and outcome measures from which to choose for improvement-based incentive payments. Additionally, it is important to monitor how KPIs are

generalized across all populations. Cohort comparisons are necessary in order to develop more meaningful measures for specific subpopulations.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

While a combination of EHR and claims data would be ideal, it is important to utilize current functionality while developing future functionality. There is much variability in degree of EHR adoption across PCMPs. Many providers are not currently on EHRs, and those that are may be at different stages of implementation. Colorado does not currently have a centralized HIE that allows for all data elements to be captured and analyzed at a state-wide or regional level. Although there are several limitations with using claims-based measures, claims ensure a common language that makes standardized reporting possible. When raw claims are available, ad-hoc analysis incorporating utilization, clinical, and financial variables can greatly inform both care coordination at the individual level as well as population health management. We therefore suggest bi-annual claims-based measures to account for the typical 90 day claims lag, with a gradual phasing-in of EHR-based measures that have particular relevance to integration.

74) Incentive payment frequency. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	
Quarterly	✓
Annually	
Other	

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

Fixed costs include technology, office space, staffing, and other customary costs associated with accomplishing required operational tasks.

HEALTH INFORMATION TECHNOLOGY (HIT)

78) HIT investments by organizations. For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	✓	
Digital care management tool	✓	
Care transitions alerts		✓
Electronic Health Records (EHRs)		
Health risk assessment software	✓	
Practice assessment tools	✓	
Practice management tools (scheduling, billing)	✓	
Client web portal for communicating care plan, services, benefit enrollment	✓	
Patient education/wellness tools	✓	
Provider/case manager directory	✓	
Shared decision-making tools	✓	
Telemedicine software	✓	
Other:		

79) Importance of technology by type. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

(Please see the table below.)

Tool	1 (least)	2	3	4	5 (most)
Population analytics / reporting / dashboard					✓
Care management tool					✓
Care transitions alerts					✓
Electronic Health Records (EHRs)					✓
Practice assessment tools				✓	
Health risk assessment software			✓		
Practice management tools (scheduling, billing)			✓		
Client web portal for communicating care plan, services, benefit enrollment					✓
Patient education wellness tools					✓
Provider/case manager directory				✓	
Shared decision-making tools				✓	
Telemedicine			✓		
Other:					

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

The primary barriers are financial and operational. Practices that can finance information technology enhancements are not always convinced that the return on investment will justify the expense. There are additional financial and other expenses that are incurred. Specifically, employees need to be trained on how to use the technology, and workflows and associated protocols need to be established. Additionally, behavioral health providers are not eligible for Meaningful Use incentives to offset the cost of EHR adoption or the provider licensing fees that some EHRs require. The "new" information gleaned from the enhanced technology must also be incorporated into existing quality improvement programs so that it can yield practice change. Although often desired, practice change can disrupt a practice's routine operations. There is also concern among providers about the current capacity of EHRs to manage consents and re-disclosure of substance abuse data. Finally, unless a common EHR is adopted across providers, it is cost prohibitive for the RCCO to integrate health information systems with all possible EHR platforms available to providers.

81) How can Health Information Technology support Behavioral Health Integration?

Health information technology (HIT) must allow for all treatment team clients to enter and retrieve client information. The data must also be reportable so that it can be analyzed at both the individual and aggregate levels. This can also assist initial encounter tracking, follow-up care encounter tracking, and care transitions. HIT can facilitate services that are critical in integrated care settings. For example, screening instruments tied to clinical decision support that includes treatment and referral guidelines are extremely useful in integrated settings. Additionally, HIT can be used to facilitate scheduling referral appointments in real time, to send appointments reminders, to alert the care team if high-risk clients miss appointments or do not refill critical prescriptions, and to automate information sharing between providers.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

In the next iteration of the ACC, there could be a shared resource for high-level reporting and analytics for cross-regional comparison purposes. However, if RCCOs are to assume membership clinical and/or financial risk, they should be permitted to conduct their own analyses and/or to identify analytics subcontractors with national expertise if they choose to do so. Assigning the full analytic responsibility to one shared resource limits ad-hoc analytic innovation and compromises data reliability. Any shared data analytics platform would have to include raw claims (medical, behavioral, and pharmacy). Ideally, this resource would be able to integrate EHR data. However, it is cost prohibitive for the RCCO to integrate health information systems with all possible EHR platforms that are available to providers.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

While many entities have various tools to effectuate their care management program, it is important to recognize that individuals have many people in their lives supporting their health and wellness. Each RCCO needs to be able to have the technology to support a shared care management platform to assure better coordination of care and improved health and wellness outcomes for the individuals they serve. As a core requirement, the care management tool needs to support the interdisciplinary care team by sharing access of the client's focused care plan for individuals receiving care coordination services.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

We recommend a single shared public health management (PHM) tool in recognition of the scope of the projects and the new issuers that are likely to be encountered. This tool ensures the entire care team adheres to a single set of clinical protocols, and leverages similar technology to strengthen the delivery of care. Additionally, it allows the team to interpret and use the patient data to have a direct and tangible impact on the patient's overall experience and health outcomes.

A shared PHM tool should account for the complete physical, behavioral, and psychosocial environment needs of the patient. The data should be secure and easily accessible through a Web portal to support information sharing among the patient, family, RCCO staff, physical and behavioral health providers, and other members of the care team. The application should store and display critical information and offer a holistic view of the patient's care.

In addition to the obvious benefits of data-sharing noted above, other criteria to apply would include but is not limited to the following:

- Structured data collection capabilities
- Custom reporting and analytic tools
- Application of evidence-based guidelines
- Use of risk stratification analytics to identify chronic care/co-morbid cases
- Automated communications to patients, RCCO, clinicians and care team about patient care needs such as:
  - Gaps in recommended care
  - Failed to fill prescriptions
  - Missed appointments or immunizations

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

An online directory of Medicaid providers and services, accessed via the Web or a mobile device, would offer users access to a provider directory. Regardless of the route used, users would be able to search the network database to locate a provider online from their computer or mobile device.

Provider searches would be conducted by simply entering the user's physical address, the distance they are willing to travel, and the type of provider they would like to locate. Based on the search criteria selected, the search results will supply the appropriate provider information and a map to offer driving directions to easily help locate the provider.

To offer the most useful data, the online directory should include the elements listed below.

RECOMMENDED PROVIDER DIRECTORY DATA ELEMENTS	
Provider name	All practice locations/addresses
Telephone numbers	Office hours
Foreign languages spoken	Provider Type
Provider Licensure Level	Clinical specialties/modalities
Practice limitations or age restrictions	Disability accessibility
Accessibility to Public Transportation	If accepting new patients

Additionally, to offer efficiency and access to the most current information, the source data of the provider directory should be an integrated component of the information management system. This integration ensures that as updates are made to the provider file, the changes are available in the provider directory in real time.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

RCCOs should provide secure Web-based solutions offer providers with convenient access to real-time clinical data, available twenty-four hours, seven days a week. Online capabilities to minimize administrative burdens allow providers to access and conduct actionable tasks including but not limited to the ability to communicate with patients via a secure messaging center, view eligibility and benefits, submit requests for authorizations, create and submit treatment plans, submit claims, updating practice information, and access outcomes and provider profile reports.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

The following HIT solutions would benefits clients, providers, and RCCOs:

- **Patient portals**: Secure web portals designed to help providers and the RCCO to share records and other useful information with patients and engage them in self-management.

  Patient portals should include access to helpful resources such as a repository of credible and educational health information, access to the shared PHM tool, and allow clients to view benefits, claims, and authorizations. Clients should also be able to conduct provider searches, set up appointment and medication reminders, and communicate directly with their provider.
- **Provider portals**: Secure web portals designed to help providers and the RCCO to share records and other useful information about patients.

As noted above, the provider portal should offer access to the shared PHM tool, allow providers to communicate with patients via a secure messaging center, view eligibility and benefits, submit requests for authorizations, create and submit treatment plans, submit claims, updating practice information, and access outcomes and provider profile reports.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

Active, timely, and continuous communication, training, and technical assistance are essential components of contract compliance. RCCOs should be prepared to offer providers, patients, and other stakeholders using their HIT initial orientation sessions on how to use the HIT, and continuous communication and training opportunities via the web portals.

The RCCOs' HIT infrastructure should be one that is flexible and designed to easily adapt to regulatory and other contractual changes. The IT resources should be staffed sufficiently and with experienced IT professionals to support the ongoing needs of the Colorado ACC contract.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

Although the PHM solution offers data at a more aggregated level, the CORHIO or QHN offers more robust set of data such as admission and discharge summaries and actionable data like lab results. Once the both sets of data are brought together they can offer great value at the point of care and an enterprise reporting level; this type of data is specifically useful for performance or risk-based programs such as the ACC.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 083

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

UnitedHealthcare
COMMUNITY & STATE

Kevin Dunlevy-Wilson
Department of Health Cara Policy end Flnencing
Accountable Cere Collaborative Strategy Unit
1570 Grent Street
Denver, CO 80203-1818

RE: RFI UHAA 2015000017: *Accounteble* Cere *Colleborative Request for Informetion*

Delivered vie email: RCCORFP@state.co.us

Dear Mr. Dunlevey-Wilson:

Enclosed please find e response to the ebove referanced Request for Informetion (RFI). We eppreciate the opportunity to provide feedback to the Depertment of Health Cera Policy end Flnancing (HCPF) on the Accountable Care Collaborative (ACC) program and the potentiel to improve upon the design for Regional Cere Collaborative Organizations (RCCOs). We epplaud the work the State has accomplished through the development end implementetion of ACC and believe the State hes the opportunity to further enhence the care provided by the State's RCCOs.

Our response is influenced by our more then 30 years of serving Mediceld beneficieries and working closely with providers end heelth delivery systems to drive innovation and performance. We have provided HCPF with suggestions based upon our nationel Medicald experience in 24 states end with neerly five million beneficiaries. We believe Colorado hes the opportunity to leverege a provider-based epproach end echieve systemic performance through the development of system-wide supports thet reduce fragmentation end eneble the State to address the needs of all Coloradens served by Mediceid.

We look forward to ongoing opportunities to working with Colorado to provide our expertise to support the work of the ACC end the RCCOs. Should you have eny questions, I can be raeched at 202-654-8281 or catherine_k_anderson@uhc.com.

Sincerely,

Cetherine K. Anderson
Vice President, State Programs

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Catherine Anderson
Location: 701 Pennsylvania Ave, NW
Washington, DC 20004

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: UnitedHealthcare Community Plan
Location: City, County, State.
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted -- Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☐ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Click here to enter text.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Given the upcoming competitive procurement we hove elected to not respond to the questions in this section.

☐ Since before the program was implemented.

General Questions

1) What is working best In the Accountable Care Collaborative (ACC) right now?

Colorado has been progressive in piloting innovative health care payment and delivery reform strategies to move the Medicaid system away from unmanaged fee for service (FFS) with the implementation of the ACC. Serving as the primary infrastructure for the Medicaid program, the State has predominantly favored transforming the system utilizing ACC strategies as an alternative to risk bearing managed care. The State has been able to achieve moderate successes in cost savings around a few Key Performance Indicators (KPIs) however many opportunities are available to advance reform in the next phase of the ACC program.

The State has also demonstrated leadership in its efforts to consolidate purchasing authority for the majority of all Medicaid programs under the Department of Healthcare Policy and Financing (HCPF) with its recent move of the department of Division for Developmental Disabilities under HCPF. While the responsibility of program administration for behavioral health services still remains in the Department of Human Services, HCPF is responsible for contracting with Behavioral Health Organizations (BHOs). The recent organizational changes have consolidated the majority of the Medicaid purchasing power authority down to HCPF and as a result of those efforts the State is better positioned to explore purchasing strategies to drive deep system reform across Medicaid and long-term services and supports (LTSS) waiver programs.

2) What is not working well in the ACC Program?

Similar to other states that favored accountable care structures – ACC system performance has been hindered largely due to the regional and fragmented nature of the infrastructure, the proficiency of the system's data analytics, and the limited Regional Care Collaborative Organizations' (RCCOs) capacity to manage the growing Medicaid population, specifically complex populations, and the growing administrative responsibilities associated with advancing system reform.

- *Regional Structure.* The State has favored regionalism to allow for a customized approach to address the unique delivery system characteristics within a specific area – such as special needs of the beneficiaries, network development, and enrollment capacity. However as the system is maturing the variation stemming from the regional micro systems is limiting system performance, creating disparity and fragmentation between regions that impacts quality, outcomes, and cost savings. This also translates to dramatic variation in the beneficiary and provider experience. Additionally because there is no core ACC program framework the State has limited ability to compare or drive performance across regions.

- *Data Transparency and Analytics.* The data model is a post service claims based data repository system that does not currently have the capability to provide real time information to the RCCOs. Because of this, the information distributed to RCCOs via regular reporting is retrospective and often lags by three to four months due to the time it takes physicians to

submit claims. Additionally the claims experience is limited - behavioral health information, waiver services, and utilization for non-ACC beneficiaries does not currently feed into the data model which further limits the utilization detail available to RCCOs. We recognize the State's efforts in both acknowledging this as an issue and long term strategy to improve access through the Colorado Medicaid Management Innovation and Transformation (COMMIT) project. Experience, however, tells us that multi-year MMIS implementations are likely not designed to keep pace with Colorado's desire for innovation and in support of the imminent next phase of the ACC program.

- *System Fragmentotion.* System fragmentation exists within the ACC program and across the Medicaid system as a whole. The ACC program is not currently accountable for covering all Medicaid eligible populations and administering all Medicaid covered services (physical, behavioral health, and waiver benefits). The separate administration of vital services and/or programs limits the Medicaid system's ability to support holistic, person-centered care management and does not support accountability at the state level. Within the ACC, RCCOs have been given significant latitude to develop program structures, financing models and activities based on locally identified opportunities. Because of this autonomy quality measures, alignment of provider incentives, care management approaches and integration strategies creating significant inconsistencies in beneficiary experience, performance outcomes and initiatives to drive future reform.

- *Attribution of Beneficiories to RCCOs.* As we know the State is already aware, the attribution model for assignment of beneficiaries to RCCOs has created challenges with accurately identifying the primary care provider of record. The downstream impact of that is an inability of providers and/or RCCOs to identify beneficiaries participating in the ACC in order to target efforts to impact benchmark performance. The key to developing a successful attribution model is provider awareness, as early as possible, of which patients are attributed to their practice to maximize the potential impact of strategies to holistically manage the patient. Additionally practice churn affects accurate attribution and the data transparency limitations likely exasperate this issue in the current system. Without a model accountable for the entire Medicaid system that includes enabling visibility to utilization data across the entire accountable care system and the analytical capability to track patient movement it may be difficult for practices to accurately identify ACC members that frequently change physicians.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

   As discussed in the answer to question two, the separate administration of behavioral health creates system fragmentation that limits the Medicaid system's ability to provide true person-centered care and align incentives across all of Medicaid. Within the behavioral health system, substance use disorder (SUD) benefits are carved out of the BHO contract and administered in a separate system creating deeper fragmentation within the behavioral health system and Medicaid in general.

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

RCCO and BHO collaboration is driven by the individual organizations' desire to collaborate and therefore very disparate. The State allows RCCOs substantial flexibility to determine the extent of the BHO collaboration necessary to serve their beneficiaries often creating challenges with the sharing of information between the two systems. This issue is further complicated by the regional service area incongruence between the ACC and BHO programs. The lack of alignment creates the need for a RCCO in some instances to work with multiple BHOs which complicates partnerships.

Colorado – like many other states – has developed approaches to Medicaid reform strategies born out of the organizational structure of the State departments – specifically the Department of Healthcare Policy and Financing (HCPF), its sub agencies and the Department of Human Services (DHS). As such the State has historically run separate programs underneath the distinct authority of each department which has resulted in detached systems with limited connectivity. Although purchasing authority has been recently consolidated under HCPF there are still two different purchasing strategies being employed – fee for service coupled with an administrative fee for ACC versus capitation for BHO – resulting in misaligned incentives thereby creating barriers to integration and system-wide transformation. Additionally the bifurcation at the agency level tends to institutionalize the cultural separation between behavioral health and physical health programs throughout the delivery system and between vested stakeholders.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Opportunities exist to enhance the existing ACC and BHO infrastructure to strengthen the system's core capabilities and partner those capabilities with the systemic discipline of a statewide approach that supports regional development, introduces global payments into unmanaged Medicaid programs, and has the aptitude to make targeted intellectual and financial investments to reform the entire Medicaid system. Foundational to the reform strategy is a disciplined approach which bridges delivery system fragmentation to support integration, creates connectivity across all Medicaid programs (ACC, LTSS and behavioral health), and builds provider capacity to manage complex populations such as the Medicare and Medicaid dually eligible individuals and individuals needing LTSS. Additionally this enhanced strategy would allow for the development of capabilities that augment data analytics currently available – for example: the creation of real time utilization notification and connectivity to behavioral health, LTSS and Medicaid fee for service systems.

Examining the varied infrastructures and financial models that currently exist in the Colorado Medicaid system, the State would not be able to deploy an enhanced model. Additionally payment reform alone is not a sufficient way in and of itself to incent change in the way care is delivered in the State. Delivery system reform needs to focus on breaking down the barriers between traditionally separate systems to achieve true integration, align RCCO and BHO incentives, and enhance data analytics and system investment to most effectively utilize the existing ACC and BHO infrastructure without creating additional system complexity. We would recommend the State develop a state-wide model that is accountable for scalable statewide transformation of the Medicaid system data analytics, bringing to market core, scalable capabilities to progress the health care delivery system towards pay for performance, and is able to take on a variety of payment models to create system cohesion and capacity to manage all Medicaid populations (those already in some type of managed system and those that remain in fee for service).

Secondary to the enhanced model discussed above is the regional organization of various Medicaid delivery systems. The State should consider regional alignment of service areas for all Medicaid programs (ACC, BHO, SUD, and LTSS). Broad system goals should be reflected in procurement requirements to ensure alignment with program goals and advancement of Medicaid modernization as discussed in the State vision for the next RCCO procurement. This will enable the State to identify sophisticated, experienced, innovative and qualified RCCOs capable of participating in the evolution of Colorado's Medicaid system.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☒	☐	The different reimbursement methodologies – capitation and fee-for-service combined with per member per month administrative fees – create barriers to integration because of the misaligned incentives. It is recommended the State develop a state-wide model that connects the two separate systems, effectively utilizes the existing infrastructure, aligns performance goals and is capable of administering a variety of payment models.
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	Broad misalignment of program administration such as rules, reporting, financial incentives, and contract terms across two separate systems will be a barrier to true integration. While purchasing power has been consolidated underneath HCPF the administration of behavioral health system still remains in the Office of Behavioral Health. This bifurcation tends to institutionalize the cultural separation between programs throughout the delivery system and between vested stakeholders. Agency consolidation can assist with addressing the challenges that exist in the bifurcated administration of services. Short of agency consolidation the State should identify and remove to the extent possible barriers and/or conflicts that exist with the two agencies.
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☒	☐	We have found in certain circumstances that restrictions in privacy laws prohibit the sharing of clinical information among providers which can be problematic when trying to achieve integration. System development that enables this level of information management as well as clarity on what can be shared and with whom is important to advance integration approaches. Patient consent mechanisms are essential.
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☒	☐	RCCOs and other Medicaid contractors are not currently funded to develop these advanced approaches and because of the system fragmentation a single system would not have the authority or incentive to provide a sustainable solution for all programs. The optimal approach would be a statewide model that builds on the existing data capabilities to expand data analytics, technical support and innovative technologies across all systems. This model will allow the State to leverage the suite of technology tools available through private contractors to enhance system performance. More broadly this will allow the State to advance data solutions at the regional level faster, at a lower cost and with less administrative burden for State while creating transparency within the system which does not exist today.
Training	☐	☐	
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

b. How should RCCOs prioritize who receives care coordination first?

c. How should RCCOs identify clients and families who need care coordination?

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

In order for the State to achieve true integration that supports a holistic, person-centered approach the Medicaid system should facilitate coordination of all services across all Medicaid programs (physical, behavioral, long-term supports and services and social supports). An approach short of that will be limited in its ability to maximize system performance in alignment with State goals. Building on the enhanced model discussed in the answer to question 7, the State can utilize the statewide vendor to create connectivity across the entire system and build capabilities to effectively leverage the existing infrastructure to, for example, identify the lead organization responsible for primary care coordination responsibilities based on the beneficiary's needs. Care coordination would be supported through enhanced data analytics and transparency, organized collaboration between systems, and focused performance metrics that will enhance the system's ability to facilitate person-centeredness and ease the administrative burdens. Additionally the statewide model recommendation should offer care coordination services for populations that remain in unmanaged Medicaid fee for service.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

RCCOs and other Medicaid partners need access to actionable, critical and complete information on their attributed panel of beneficiaries to effectively coordinate benefits and services in alignment with a person-centered approach. Real time information should be available to assist care coordinators with understanding the beneficiary's risk level, gaps in care, and current inpatient and emergency room utilization. Thoughtfully designed information technology infrastructures that accomplish this type of data connectivity are complex and require financial investment to develop competencies. Capital to invest in these solutions is likely limited and strategic approaches to incentivize investment

are not sufficient when considering the breadth of the other competing interests for all stakeholders (RCCOs, BHOs, PCMPs, hospitals, HCPF). As an alternative the State should consider a state-wide model that facilitates consistency and broad adoption core competencies such as information technology solutions across the Medicaid system as a whole. The independent nature of the RCCOs and BHOs has created varied adoption of supportive technology and it will be difficult to address the regional and program variation without a state-wide system that facilitates partnerships and connectivity.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability	☐	☐	☐	

& employment				
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	
Health literacy	☐	☐	☐	
Housing	☐	☐	☐	
Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	
Transportation	☐	☐	☐	
Other	The State's expectations of coordination of social supports – such as those listed in this chart – need to be appropriately funded through rates and reflect the data transparency limitations that exist in the current system. RCCO per member per month administrative fees provide for limited financial opportunities to take on and/or develop sophisticated capabilities to develop robust strategies to facilitate coordination of services that are outside of direct authority of HCPF.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	

Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	The State should avoid mandating participation of a representative based on clinical credentials and allow the lead organization responsible for care coordination to determine the appropriate staffing based on the needs of the beneficiary. For more complex beneficiaries an interdisciplinary care team (ICT) approach may be employed and the determination of participants on the ICT should be driven by the beneficiary's needs and preferences. The State should avoid mandating the make-up of the ICT or the credentials of the care coordinator (for example, nurse versus social worker versus behavioral health). Allowing flexibility within a baseline framework to develop staffing resources based on beneficiary needs ensures effective alignment of staff based on those served by the program. Procuring vendors experienced in clinical approaches for complex populations in the next cycle will allow the State to leverage their core competencies as opposed to the State developing the model.		

17) Care coordination requirements for specific populations. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment: The State should leverage the core competencies of its vendors to, for example, risk stratify the population they are serving to prioritize service allocation based on individual needs. For example beneficiaries determined to be at the highest risk based on a clinical assessment would receive robust, high-touch care coordination support and those with lower clinical complexity would only receive periodic support. We would encourage the State to not develop care coordination requirements based on individual populations as clinical complexity and/or severity within those populations is going to vary. The model should develop system-wide baseline requirements and allow for the use of proprietary clinical tools to assess the needs of beneficiaries to effectively align benefits and resources. The intent of any mandated standardization should be to allow for the collection of standardized elements without requiring standardized assessment tools.			

Procuring vendors experienced in clinical approaches to effectively address the needs of varied complexity in the next cycle will allow the State to leverage their core competencies as opposed to the State developing the model. The enhanced model discussed in the answer to question 7 can be leveraged to fill gaps that may exist in the ACC and BHO models to ensure the system is capable of coordinating care for all populations listed above.

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

The State must provide sufficient payment to cover the costs of administering the ACC program considering the terms of the agreement with the RCCO. Without adequate funding, the State will lose the benefits of innovations and savings that RCCOs provide. Rate development should consider the resources necessary to clinically manage the Medicaid population including quality improvement initiatives and beneficiary engagement strategies. Accordingly, the State should consider developing unique rates for populations not currently in the ACC program or complex populations such as those requiring LTSS waiver services or individuals with developmental disabilities to account for the high cost associated with care coordination needs. The use of a state-wide model would allow the State to offer care coordination services to populations that are in Medicaid fee for service.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

The State should allow flexibility for the organization to determine appropriate staffing levels with appropriate HCPF approval. This ensures the model effectively aligns staff based on the individuals served by the program. This is acutely important in the ACC program because the State's attribution model does not consider the cohort mix of beneficiaries attributed since there is only a single RCCO serving each region. Allowing flexibility in the staffing requirements enables the system to manage a population with a range of clinical severity.

a. Care coordinator to client ratios. If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

We recommend that performance be measured as a function of clinical performance, beneficiary satisfaction, utilization standards and quality of care. Typical tools used to benchmark quality and measure performance in accountable care models are Healthcare Effectiveness Data Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) and baseline performance targets based on the specific practice and/or RCCO. Care coordination in and of itself should be viewed as a core competency evaluated during procurement and measured as a function of process.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

We would also encourage the State to evaluate the existing Medicaid rule prohibiting outreach to Medicaid beneficiaries assigned to RCCOs. The rule pre-dates the ACC implementation and has its roots in the State's negative experience with capitated managed care. This legislative barrier significantly impacts a RCCO's ability to locate attributed members with no prior service history and ultimately limits the program's ability to ensure care coordination for all Medicaid beneficiaries.

The State should design the upcoming procurement to collect meaningful information and appropriately score experience in alignment with program goals and advancement of Medicaid modernization both in the short and long term. This will allow the State to leverage the private sector's skills and experience in a more robust way to advance reform consistent with HCPF's strategic vision to transform the healthcare system – specifically strengthen mental health, substance abuse, and physical health integration; develop ACC sensitivities to the diverse needs of Medicaid beneficiaries; and support an integrated, multi-disciplinary delivery system with a focus on person-centered care. Additionally developing a state-wide model would allow the State to transfer a significant amount of the administrative responsibilities—claims processing and call centers—to the private sector, thereby alleviating that burden on limited public resources.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

All core system functions of the ACC model should be standardized across all regions to bring the system in alignment at the state level. This should be done at an elemental level and allow for enough flexibility within the core standards to adjust for regional variances at the community level and encourage innovative approaches to provider partnerships and incentive models to advance system reform. This level of standardization will allow for performance comparison, efficiency, and affordability of central functions such as data collection and reporting, and create administrative simplification. This vital step in the next phase of the ACC program will develop the necessary framework to create accountability at the state level and prepare the State to integrate medically complex populations and services into a centrally aligned and connected system. The state-wide model coupled with a partnership with a dynamic organization that is able to customize strategic supports at a regional level, introduce and align payment strategies across disparate systems, and be held to overarching programmatic goals will allow the State to advance reform strategies at a faster pace and in alignment with its change agenda.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes, please see the answer to question #7.

28) Should the BHO region maps change? Why or why not? If so, how?

Yes, please see the answer to question #7.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

As previously discussed, we would recommend the State evaluate the existing Medicaid rule restricting the types of outreach and direct contact that RCCOs can use to engage Medicaid

beneficiaries. The rule pre-dates the ACC implementation and has its roots in the State's negative experience with capitated managed care in the 1990s. This legislative barrier limits the likely success of innovative models of care and the program's ability to ensure care coordination for all Medicaid beneficiaries.

We would encourage the State to review and adjust its attribution model to ensure it is effective at assigning beneficiaries to RCCOs. In addition to the limitations discussed in the answer to question two, the current attribution model makes a one-time assignment of a beneficiary to a RCCO based on the address on record. While this is effective at the out-set, beneficiaries often move in and out of the service areas and the current system does not allow for re-attribution when the State becomes aware of a new address post the primary assignment. This issue coupled with the inability of the RCCO to outreach to Medicaid beneficiaries that do not have a record of using services makes tracking and engaging attributed beneficiaries difficult. This is an acute issue with individuals that are returning to the community from incarceration or beneficiaries that are precariously housed or homeless. Also we would encourage the State to consider refining the rules governing RCCO assignment for beneficiaries that elect to seek services with a PCMP that is in another region. If the State elects to maintain this freedom of choice it is recommended the beneficiary be automatically reassigned to the RCCO that administers the Medicaid program for the region in which the PCMP provides services. This aligns performance accountability to the appropriate RCCO and supports upstream accountability at the State level as discussed in the enhanced model throughout this response.

We would encourage the State to mandate participation any willing Medicaid provider in the ACC program and for the State to set the rates during the first few years of the second phase of the program. This will encourage market acceptance of ACC tactics and ensure penetration of reform strategies advanced via the ACC model. The participation mandate should not limit the ability to negotiate incentive models or unique payment terms with mutual support of providers.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

Currently the benefits administered under the ACC are not comprehensive. There are several carve-outs such as behavioral health, substance use disorder and LTSS waiver programs with the most complex populations still in unmanaged fee for service. A comprehensive benefit design will result in better coordination of care in a person-centered approach by eliminating fragmentation and confusion. For optimal results, the State should include all State Plan and waiver benefits, including but not limited to LTSS (including both nursing home and home and community based services), transitional services (such as "Money Follows the Person"), pharmacy benefits, and behavioral health services in a single system. Recognizing the current limitations in the ACC, BHO and LTSS systems and the lack of connectivity between all, it is highly unlikely the State will be able to advance innovative solutions relying on a region up approach through disconnected systems using the financial models that exist today. Even the most well thought out attempts to address these challenges by the State will likely result in slow, iterative advancements. Developing a statewide framework with a partnership with the private sector can effectively leverage the existing infrastructure, create system-wide accountability and advance the State's reform goals at a faster and more cost effective pace.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

This is not necessarily to best solution to attempt to resolve some of the existing challenges in the ACC system. We fear if the State introduces a second RCCO per region it will only intensify regional variation, system complexity, fragmentation and stress at the point of service for all stakeholders. Critical mass of beneficiaries is also another factor for consideration and if this would create disincentives for RCCOs to invest in system improvements if competing for membership within the region. Alternatively the system should be structured in such a way to create statewide accountability for the administration of the Medicaid system as a whole – encouraging integration, creating a statewide infrastructure, facilitating benefit comprehension, and program connectivity.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

Interagency collaboration across all departments administering programs effecting Medicaid beneficiaries is a fundamental step to aligning program goals across the public delivery systems. Because of the historical separation between the agencies (HCPF, the Department of Public Health and Environment, DHS), each agency likely has different leadership, missions and staff expertise. Without addressing variances to the degree that allows Medicaid transformation to progress in the same direction the State will be challenged to scale reform strategies across the entire Medicaid system. While the State has made tremendous strides in the alignment of purchasing power underneath HCPF as previously discussed, there are still opportunities to advance deeper alignment of state purchasing models (capitation versus fee for service), payment policies, and contracting requirements across systems. Additionally creating a central, state-wide infrastructure that is responsible for the system improvement such as regional consistency and accountability across all programs – independent of agency authority – will be key to driving program efficiencies and system reform.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

Please see answer to #35

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

The churn of individuals newly eligible for private insurance via the exchange and Medicaid is a documented phenomenon that can create challenges for beneficiaries. In an effort to scale efficiencies and leverage the State's successful work in developing and implementing the Connect for Colorado insurance exchange, HCPF should consider the opportunity to use the enhanced model (discussed in answer to question 7) to create connectivity between Connect for Health Colorado and the Medicaid system. Creating a single entity responsible for the overarching administration of the Medicaid system and developing capabilities that allow for the seamless transmission of data (for example, transferal of eligibility between the two systems) can stabilize the transition to the extent possible for beneficiaries. Real time notification of eligibility shifts will also reduce gaps in care and ensure timely access to necessary for services for affected beneficiaries.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Please see answer to #35.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

To the extent that the State allows the expansion of community health workers in the Medicaid system we would recommend the appropriate funding for such services whether they are encountered as a medical expense or otherwise actuarially accounted for in the rates.

Needs to be a medical expense, needs to be encountered

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

Incorporating cultural competency as a component of the procurement will assist the State in identifying RCCOs with core competencies and experience in this area.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Effective management of acute transitions and emergency room diversion initiatives require real time notification to effectively coordinate care to avoid future inappropriate utilization. Without this level of transparency there will be limited opportunities to intervene and appropriately redirect care during acute episodes. Additionally, advancements of innovation at the regional level to develop these capabilities have been minimal and disparate. The State is focused on a long term strategy through its Colorado Medicaid Management Innovation and Transformation (COMMIT) project, however, our experience tells us that multi-year MMIS implementations simply are not designed to keep pace with Colorado's desire for innovation.

Developing a statewide model maximizing the existing infrastructure and partnering with the private sector to build system competencies as discussed throughout this response affords the State the opportunity to modernize its technological and claims infrastructure for the Medicaid system as a whole. This model will also advance data transparency allowing for the development of innovative emergency room utilization initiatives spanning both physical and behavioral health admissions advancing integration. Deploying these recommendations will modernize the Medicaid system's

technological infrastructure at a lower cost and reduce the complexity of its traditional Medicaid Management Information Systems (MMIS).

S2) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

We would encourage the State to not mandate any of the following identified types of assistance. The inherent system is not adequately funded to support mandating RCCOs to provide this level of provider support. It is more conceivable for the State to develop a model in which these services and supports are universally provided across all regions and systems.

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐

Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

Through our experience with multiple payment reform strategies we have learned that effective, efficient transformation takes coordination, robust collaborative care tools, strategic infrastructure investments, and experienced resources to provide one-on-one practice support. This ideal creates a model where all key constituents in the community can successfully evolve. As stated in the answer to question 53, the inherent system is not adequately funded to support mandating RCCOs provide this level of provider support. Payment reforms alone are also not sufficient to change the system. In order to impact the delivery of care effective tools and supports for providers are necessary.

As discussed throughout our response RCCOs and other Medicaid partners need actionable, critical information on their attributed panel of patients. The most successful accountable care systems are able to customize assistance at the individual practice level coupled with targeted investments to support practice transformation (e.g., information technology solutions such as electronic health records, data analytics capabllities, health information systems, total cost of care management, and data collection methodologies that support performance measurement and reporting). Thoughtfully designed IT infrastructures that accomplish data connectivity across systems are complex and require a financial commitment to develop competencies. Capital to invest in these solutions may be limited and therefore it is important for the system to develop tailored incentive strategies that focus system investment and encourage the use of technology that enhances performance. For example, compensation initiatives that encourage embracing the use of certified electronic health records as a performance measure to earn a financial incentive facilitate adoption. For these reasons, it is more conceivable for the State to develop a model in which these services and supports are universally provided across all regions and systems. An all-inclusive approach to offering sophisticated tools and resources will enable the system to become more adapt at driving quality outcomes and controlling costs. This model also encourages the customization of tools such as evidence-based guidelines and references at the point of service, real-time utilization tracking, and practice coaching to implement evidence-based care based on the individual practice needs to assist with meaningful transformation.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

There is no way to unilaterally answer this question because not all practices will be equal in their level of sophistication, readiness to accept risk, availability of technology solutions, etc. to participate in alternative payment initiatives such as bundled payments, shared savings and up-side/down side risk. As an alternative we would encourage the State to develop a model and supporting capabilities that can provide a spectrum of supports and alternative payment options to customize the approach based on the characteristics of the practice. By creating a state-wide systemic approach, the model can create standardized assessments for practice participation in alternative payment programs and make available a continuum of options to partner with practices. This creates an approach with the necessary amount of flexibility to account for practice variation, allows for the State to maximize the number of practices engaged in payment transformation and creates much needed administrative simplification for participating practices.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

The option of using RCCOs to distribute payment to providers is going to vary depending on the individual organizations experience and ability to take on risk similar to providers as discussed in the answer to question 61. We believe the State would be best served developing a statewide model using a partner with deep experience in transformative practice strategies to most effectively leverage the existing infrastructure and advance alternative payment strategies at a swifter pace. Certainly if the State wants to explore deployment of more advanced value based purchasing strategies with RCCOs they should require potential ACC bidders to demonstrate sophisticated abilities to develop strategic partnerships with providers up to and including experience with value based partnerships

such as bundled payment, shared savings and up-side and down-side risk during the upcoming procurement.

Approaching system reform at the state level and recognizing the need to develop robust, flexible solutions that allow a range of shared-saving and risk-bearing options informed by RCCOs' and other Medicaid contractors' experience with managing risk will assist with determining the right balance of accountability, integration and activation to establish the most complete, effective care for Colorado's Medicaid beneficiaries. Additionally system transformation needs to be sequential across the spectrum of value based contracting strategies to ensure success.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Yes, all RCCOs should be paid on the same Key Performance Indicators (KPIs). Narrowing KPIs to a small core set of indicators that measure system performance in alignment with state transformation goals across all regions uniformly progresses system transformation and eases the administration burden at the point of service. Additionally it creates a system wide concentrated effort around the core metrics to begin to minimize the regional variation. RCCOs should be allowed the flexibility to determine performance programs for the individual practices in their networks. Allowing flexibility to adjust performance measurement based on an individual practice allows the system to account for variations in practice sophistication and develop innovative performance incentives programs to advance transformation.

Performance metrics need to be sensitive to the current data limitations to ensure performance is achievable. Developing the statewide enhanced model will enable the introduction of more robust KPIs assuming the existing data transparency limitations are addressed.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Due to a position of favored regionalism in the current system, the State should benchmark performance based on individual RCCO performance as compared to the total Colorado system. Said another way benchmarking needs to consider the individual performance of the RCCO and be a component of how the RCCO compares to the performance of other RCCOs to establish statewide benchmarks and performance goals that are realistic for the ACC. It is important that performance metrics be established at the state level and aligned with HCPF's goals for system integration and transformation.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

Performance payment should only be tied to metrics where data is available and performance can be influenced. As discussed throughout our response, we would encourage the State to consider an alternative model that develops core data sharing capabilities through a statewide contractor and universally facilitates the dissemination of information across the entire Medicaid system. Short of doing so will severely limit the State's ability to foster transformation beyond performance improvement that has been realized to date.

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Given the competitive procurement we are electing to not answer this question. Core competencies and innovations – such as those listed below – should be evaluated and appropriately scored during procurement.

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐

Other:	☐	☒

79) Importance of technology by type. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☐
Care management tool	☐	☐	☐	☐	☐
Care transitions alerts	☐	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☐
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

The State should consider a state-wide model that facilitates consistency and broad adoption of core competencies such as health information technology (HIT) across the Medicaid system as a whole. The independent nature of the RCCOs creates varied adoption and use of the HIT.

81) How can Health Information Technology support Behavioral Health Integration?

The State should consider a state-wide model that facilitates consistency and broad adoption of core competencies such as HIT among other information technological solutions across the Medicaid system as a whole. The use of HIT in and of itself will only assist with service integration if there is broad adoption of HIT across Medicaid and if there is system connectivity to support the

dissemination of information. The independent nature of the RCCOs and BHOs creates varied adoption and use of the HIT that will be difficult to address without a state-wide system that facilitates partnerships and connectivity.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

Please see answers to question # 2, 8, 13 and 51.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 084

Accepted by: KJDW

Notes: Added standard cover sheet; revised error in numbering

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Tonya Wheeler
Location: 1660 S. Albion St. Ste. 420

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Advocates for Recovery
Location: Denver, Denver, CO 80222
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organjzation
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Recovery Community Organization

Are you currently involved in the ACC program?

☐ Yes
☒ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
No

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
N/A

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☒ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

2) What is not working well in the ACC Program?

3) What is working best in the Behavioral Health Organization (BHO) system right now? BHO's are supportive of recovery support services, supportive of peers receiving adequate and appropriate training, inclusive of peer feedback and response.

4) What is not working well in the BHO system? It is still difficult for the community to access the full continuum of behavioral health care, treatment and services. BHOs only contract with treatment providers, not recovery community organizations. BHO's are not including recovery community organizations as contractors in the continuum of care. The BHOs have long term experience with the mental health community, but not as much experience working with providers of substance use disorder services.
5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

   Access to and coverage for the full continuum of behavioral health care, treatment and services including medication assisted treatment for substance use disorders and recovery support services provided in the community.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Full integration of recovery support services for substance use and mental health disorders into the full continuum of health care systems.

Insured access to and coverage for the full continuum of behavioral health care, treatment and services including medication assisted treatment for substance use disorders.

Behavioral Health Care programs should be able to serve as primary care providers for the patients/clients whose primary diagnosis is a substance use and/or mental health disorder.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☒	☐	Reimbursement for BHC needs to be consistent with parity so that providers are equitably reimbursed for their level of effort.
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	There are no designated funds at this time for the provision of recovery support services in the community. Recovery community organizations are not included as funded agencies in the provision of recovery services.
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Training	☒	☐	Peers should be appropriately and adequately trained as SUD peer recovery coaches and mental health peer specialists.
Others	Stigma needs to be addressed head on. Providers consciously and subconsciously stigmatize patients/clients with their language, frequently have unresolved issues/jaded perspective regarding behavioral health conditions which effect their ability to treat patients/clients effectively who are challenged by these conditions; patients/clients, fearful of being stigmatized, or who harbor shame and remorse around their behavioral health challenges, frequently avoid accessing needed health care, decreasing the likelihood of meaningful engagement in care when they need it most, before their health is in jeopardy.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

Patient- Centered – Supporting patients/clients and their families to manage and organize their own care and participate as fully informed partners in health system transformation at the practice, community and policy levels.

Comprehensive – A team of providers that is wholly accountable for all of a patient/client's healthcare and healthcare related needs. Includes prevention and wellness, acute care, chronic care, behavioral and oral healthcare and healthcare related needs.

Coordinated – Ensuring that the patient/client's care is organized across all elements of the broad health care system, including specialty care, hospitals, home health care, behavioral health care, oral health care, community supports and services, palliative care, end of life care and public health.

Accessible – Delivers community friendly services with shorter wait times, extended hours, in the patient/clients primary language, with 24/7 electronic or telephone access and strong communication through health IT innovations.

Committed to quality and safety – On an ongoing basis, utilizes a data driven process or processes to study and improve the delivery of care, treatment and services to meet the needs of patients/clients and the community.

(Adapted from the PCPCC, 2013)

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Community education and the delivery mechanism of services need to be drastically improved. Simply stated, people need to know how to get help, where to go, what they can get help for, etc.

Care Coordination

11) Care coordination is an important part of the ACC Program.
    a. What is the best definition of care coordination? Ensuring that the patient/client's care is organized across all elements of the broad health care system, including specialty care, hospitals, home health care, behavioral health care, oral health care, community supports and services, palliative care, end of life care and public health.
    b. How should RCCOs prioritize who receives care coordination first? Based on presenting health care concerns and health history, triage based on symptoms, acute vs. chronic, severity, co-occurring disorders (including behavioral health disorders), health risks (perceived and real), economic stability.

    c. How should RCCOs identify clients and families who need care coordination? See b above. Based on acuity, history of medical and behavioral health care concerns.

    d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider? Use of a unified data collection system to trend data across settings, time, and clients served.

12) What services should be coordinated and are there services that should not be a part of care coordination? Using a patient centered approach; services should be coordinated based on the patient/client and family priorities. No healthcare or healthcare related services should be excluded. Ongoing community support is key.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs? It is most important to know what their priorities for care are. It is also helpful to know their medical and behavioral health and healthcare history, what healthcare and healthcare related needs are already being met, and how can needed care, treatment and services be provided in a way that complements what is already working for the patient/client.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today? Coordination within systems, (i.e.; in hospitals, in behavioral health programs), coordination with a specific diagnostic focus (i.e.; diabetes, HIV, depression), sometimes coordination is provided across a system (i.e.; one coordinator that works across a hospital system with a patient/client that has been hospitalized and needs to access medication management and PT services upon discharge.)

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different? Disease specific care coordination

c. How can the ACC avoid duplicating or disrupting current care coordination relationships? By providing a case manager, or someone to oversee the delivery of care coordination and insure against disruption or duplication of effort. Patients/clients can also be empowered to oversee this for themselves.

d. What are the gaps in care coordination across the continuum of care? If care coordination is only provided for a specific diagnosis, or a specific set of circumstances, it is not inclusive of all of the factors that impact health and well-being. If t's aren't crossed, I's aren't dotted, there is a risk of re-occurrence or relapse. Care coordination needs to include referral and access to recovery organizations in the community for individuals with behavioral health diagnoses.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	**Should the RCCO have a role?** Yes	No	**Should the RCCOs coordinate with community supports and services?** Yes	**Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?**
Abuse, neglect, and trauma	☒	☐	☒	Assessment and education
Affordability (assistance with prescriptions or co-pays)	☒	☐	☐	

Daycare / childcare	☒	☐	☐	
Economic stability & employment	☒	☐	☒	Assessment and education
Education	☒	☐	☒	Assessment, referral, workforce development
Environment	☒	☐	☒	Assessment and education
Food access / nutrition	☒	☐	☒	Assessment and education
Health literacy	☒	☐	☒	Assessment and training
Housing	☒	☐	☒	Assessment and referral
Language or translation services	☒	☐	☐	
Literacy	☒	☐	☐	
Transportation	☒	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	**Coordinate care?** Yes	No	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☒	☐	Each of these professionals should be involved in the coordination of a patient/clients care, to the extent that
Certified Addiction Councilors	☒	☐	their clinical and/or academic expertise is relevant to the
Certified Nurse Midwives	☒	☐	Patient/client's healthcare concerns and priorities. Using
Community Health Workers	☒	☐	a "no wrong door" approach, each could be a point of first

Generalists (BA/BS/MA/MS)	☒	☐	contact, could offer referrals or could be a referral for
Health Coaches	☒	☐	Another provider. Who works as the coordinator of care
Licensed Clinical Social Workers	☒	☐	depends largely on the preference of the patient/client and their family, what their chief concerns are and who their
Licensed Marriage and Family Therapist	☒	☐	Preference is to fulfill the role of care coordination. All of these providers should be trained to be a care coordinator.
Licensed Mental Health Counselors	☒	☐	
Licensed Professional Counselor	☒	☐	
Masters of Public Health	☒	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	
Nurse Practitioners	☒	☐	
Patient Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☒	☐	
Psychiatrists	☒	☐	
Psychologists	☒	☐	
Registered Nurses	☒	☐	
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☐	
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☒	☐	

Children involved in the foster care system	☒	☐	
Children with a chronic illness	☒	☐	
Children with a serious emotional disturbance	☒	☐	
Children with medical complexity	☒	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	
Transition-age adolescents	☒	☐	
Parents and families	☐	☒	
Pregnant women	☒	☐	
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☒	☐	
Adults with a chronic illness	☒	☐	
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	
Clients involved in the criminal justice system	☒	☐	
Clients with a disability	☒	☐	
Clients in a nursing facility	☒	☐	
Elderly clients	☒	☐	
Frail elderly clients	☒	☐	
Clients in palliative care	☒	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured? It should be evaluated based on increased access to preventative care and increased patient/client satisfaction with their overall health and well-being. Outcomes should be measured based on decreases in preventable diseases, increased utilization of preventative health services, increased sense of self -worth amongst patients/clients, decreased use of EDs and urgent care clinics.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population? Vary by acuity, vary by needed services, vary by available resources within and outside the network of providers

c. Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population? Yes. Vary by acuity, vary by needed services, vary by available resources within and outside the network of providers

21)

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☒
26-50	☒
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important? Quality of life metrics (independent living, stable housing, education, vocational training, stable employment, regular exercise) – decrease in preventable diseases/illnesses, decreased use of ED, increased appropriate utilization of health care services, increased perception of self-worth, self-efficacy. Patients, families and healthcare team feel empowered as a result of their efforts at achieving and sustaining health and wellness.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Examples provided are good. Add utilization of a basic standard set of outcome measures to be reported. This would not preclude RCCOs from collecting additional/supplemental data, but would provide for more comparability between RCCOs and would serve to raise and level the playing field for consumers.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Bidder should already have community relationships as demonstrated by letters of support within their application. Role of community partners should be explicitly defined in the bidder's application and the role of the community partner should reflect the current scope of work that the community partner is currently engaged in.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

Operationalizing this proposal may result in increased competition among the RCCOs. If there is a demonstrated need for this competition, in order to increase the quality of care provided, then this may be a good move. There may be some parameters put around this though to insure that patients are not traveling extraordinary distances or spending excessive personal funds to receive care.

27) Should the RCCO region maps change? Why or why not? If so, how?
28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

Changes in legislation, policy, rules or procedures that require coverage of the full continuum of care, (i.e.: recovery support services in the community).

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region?

This would involve two or more entities operating in the same region and competing for clients and providers.

If so, why? If so, how many and where? What issues would this address?

If there is a demonstrated need for this competition, in order to increase the quality of care provided, then this may be a good move. There may be some parameters put around this though to insure that patients are not traveling extraordinary distances or spending excessive personal funds to receive care.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not? NA

34) What role should RCCOs play in attributing clients to their respective PCMPs? RCCO's should have the flexibility to insure that clients are appropriately placed into care with a PCMP based on their primary diagnosis.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

CDPHE is responsible for monitoring a wide range of public health concerns including immunizations, sexually transmitted infections, tuberculosis, and birth defects. Their efforts inform providers and the public at large about current and future health and wellness indicators. This data has a significant effect on our statewide "health care IQ" and also on healthcare spending. CDPHE serves a vital function in keeping the ACC informed about current healthcare concerns in the state and future possibilities. All ACC initiatives should be informed by CDPHE interpreted data.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

Much like CDPHE, offices within CDHS provide a similar monitoring function for specific illnesses/disease (i.e.; OBH for substance use and mental health disorders). Thus all ACC initiatives should be informed by CDHS interpreted data specific to its significance to public health.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

The ACC Program and Connect for Health Colorado should collaborate around issues pertinent to both – issues related broadly to public health and disease prevention and control and ways to improve health outcomes.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

To the extent that each of these organizations has a stake in improved health outcomes, whether due to their relationship to the insurance marketplace, as in the case of the Division of Insurance, or due to their relationship with the licensure/certification of healthcare professionals as in the Division of Regulatory Agencies, both have a vested interest in quality health outcomes. Collaboration around what works to accomplish this should occur between and with these divisions and the ACC program.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates? RCCOS should be required to employ clients, client's families and client advocates to inform the development and delivery of care, treatment and services.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region? RCCOs should be required to have both a formal, structured mechanism to engage with providers, community organizations, social service providers and others (a regularly scheduled meeting to present news, updates, etc.) and an informal way to interact with providers, community organizations, social service providers and others (one-on-one meetings in person or by phone to discuss more specific information with each). RCCOs should keep track of and report on these interactions and any resulting initiatives.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC? Think outside the box. Who are the community organizations that have not yet been tapped and how can they be accessed? (i.e.; county commissioners, school boards, teachers unions, recreation programs, local chambers of commerce, neighborhood associations, etc.)

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps? Recovery organizations are not represented for substance use and mental health disorders. Therapeutic recreation programs for individuals with disabilities are also not represented. Both of these function as a "bridge back" to the community at large for the populations they serve, an important step to prevent behavioral or physical relapse and should be considered integral to the network of care provided.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?
b. What role should pharmacies play in the next iteration of the ACC Program?
c. What role should specialists play in the next iteration of the ACC Program?
d. What role should home health play in the next iteration of the ACC Program?
e. What role should hospice care play in the next iteration of the ACC Program?
f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?
g. What role should counties play in the next iteration of the ACC Program?
h. What role should local public health agencies play in the next iteration of the ACC Program?
i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

Recovery organizations for individuals with mental health and substance use disorders should be involved, providing input as well as to serving as a resource.

45) How can RCCOs help to support clients and families in making and keeping appointments?

Effective utilization of technology that is available to clients and families including cell phones, smart phones, email and text alerts as well as social networking.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

Absolutely!

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☒
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

The same as physical health care.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you? Demonstrated understanding of the role and influence that culture has on an individual's access to and receipt of health care. Respect for the patient's (and patient's family's) right to make their own health care choices. Providing all health related information in a manner which is understandable to the patient, and confirming that they understand the information that has been provided.

b. What RCCO requirements would ensure cultural competency? Assessment of providers understanding of the cultural needs of their patient population. Determine what measures they have taken to insure cultural competency. Not just staff coursework, but actual adaptations to how care, treatment and/or services are provided to insure literacy and understanding. Also, community partners should reflect access to culturally relevant services (i.e.; faith based organizations, curanderos, recovery community organizations, etc.)

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy? Information should be provided by staff and reinforced in more than one format (i.e.: orally and in writing or orally and with pictures/diagrams), patients should always receive care in their native language, or with an interpreter that speaks their native language, family members should not be asked to be interpreters for patients. Staff should also have the ability to draw on local resources, community partners for assistance is they need it.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes? Insuring that information is available in multiple formats (written, spoken, via the internet, etc.), at all literacy levels, in the variety of languages spoken, and amongst all of the community partners that the provider is engaged with will go a long way to insure that inequality is addresses and reduced.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care? If there is a demonstrated need for this.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend? Reward promotion and access to preventative care and think outside of the box, in terms of where preventative care could be placed where it would be accessible to individuals who have not historically accessed it where it is.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☒	☐	☐	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☒	☐	☐	☐
Provide registries	☒	☐	☐	☒
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☒	☐	☐	☐
Supply behavioral health surveys	☒	☐	☐	☐
Supply other self-screening tools	☒	☐	☐	☐
Administer behavioral health surveys	☒	☐	☐	☐
Administer other self-screening tools	☒	☐	☐	☐
Prepare client action plans	☒	☐	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☒	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☐	☒	☐	☐
Provide standing pharmacy order templates	☐	☒	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☒
Provide directory of other resources	☒	☐	☐	☒
Provide materials regarding Nurse Advice Line	☒	☐	☐	☒

Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐

Others	PCMPs should utilize SBIRT broadly to assess for risky substance use and should utilize ACES to assess for trauma.

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home? Reductions in preventable diseases/ illnesses, increased immunizations (especially among children), reduction in patients' overall utilization of the ED, increase in referrals resulting in patients connecting to needed/desired care, treatment or services, PCMPs instituting and utilizing a committee structure to discuss and plan the delivery of care, treatment and services in their practice, including a patient(or patients' family member) representative in such a committee

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population? Yes.

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation? NA

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding? NA

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	
SF-12 Health Survey	☒	☐	
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☒	☐	
Focus groups	☒	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured? Claims data should show, over time, if utilization has changed, has use of EDs gone down, have more patients begun getting annual checkups, are more screens for preventable diseases been requested?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public? By all means necessary, including at your website, through the media, at various conferences and workshops.

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐

31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☒
31-40%	☒
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs? Yes and yes.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement? Yes

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures. No

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐

Annually	☒
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offertory and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐

Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☐
Care management tool	☐	☐	☐	☐	☐
Care transitions alerts	☐	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☐
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices? Cost, both for hardware, software and training, multiple platforms that don't necessarily "talk" to one another.

81) How can Health Information Technology support Behavioral Health Integration? Integration of key behavioral health elements into the patient health record (i.e.; SBIRT tools) with access to personal behavioral health information and/or screening results in the record

limited those who are designated with a "need to know" status, or to whom the patient has given consent for their access to the behavioral health information.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful. Yes

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful. Yes

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful. Yes

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 085

Accepted by: KJDW

Notes: Standard cover sheet added; formatting standardized

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Patrece Hairston, PsyD

Location: Aurora, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Children's Healthcare Access Program (CCHAP)

Location: All of Colorado

☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☒ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Pediatric Psychologist
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): **Advocate for children on Medicaid**

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Clinician and advocate.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

I provide technical assistance and consulation to pediatric practices statewide attempting to do integrated behavioral health.

I'm also a clinician and have worked in multiple behavioral health setttings with 70% of my clinical time spent with families on Medicaid.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☒ N/A

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☒ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

CCHAP will continue to be involved with the ACC and RCCO's to assist with communication, training, and advocate for policies and procedures that address the needs of children.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.
- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.
- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.
- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:
    - Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
    - If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.

- So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
- Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family and often involves different community resources than for adults

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family. This is probably the most important issue to solve. It drives measurement of outcomes, it drives the focus of the medical home to improve care, it is central to affordability of practice transformation and meeting the KPIs, and it is key to patient experience.

- Practices report to CCHAP that the attribution process is difficult to understand, use and correct. Many pediatric practices still have adults on their list unknown to them, and they do not seem to be able to remove them. Sending lists and creating spread sheets are tedious and time consuming. Practices do not have this time or expertise. Attribution needs to be fixed to create a simple way to add and remove members.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to have an impact on the Medicaid recipient's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Both family practices and pediatric practices report that the SDAC does not accurately reflect the data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on well child visits and health care screening. The RFP should ask how RCCOs and HCPF will improve the accuracy of its SDAC data and how they will take advantage of the more accurate practice-based data.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. So, the RFP should ask how RCCOs intend to deal with this

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.</u>

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level. But of course the medical home will need a portion of the RCCO's pmpm in order to afford to provide that level of care coordination.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We have heard many practices say that they are grateful that CCHAP keeps them informed..

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

- **The CPACK program** developed by CBHC is a very good program, particularly the following:
  - Assistance with finding a behavioral health provider for patients
  - Telephone consultation by a child psychiatrist

  The training component was not as helpful. We recommend that BHOs be required to provide the 2 components above as part of their new contracts

- **Ongoing development of the Independent Provider Networks.** This provides patients and families with more options in terms of selecting a behavioral health provider outside of the CMHC. This may also provide opportunities for families to gain opportunities to see behavioral health specialists in the their local communities.

- **Commitment to integrated care.** At the local level, there are many community mental health centers that are providing co-location of behavioral health providers within primary care settings. This is a step in the right direction; though the work cannot end there. In terms of standard of care, billing issues, and paperwork demands, this cannot be the only behavioral health integration effort at the BHO level. Ideally, community practices and clinics would be able to have the option of employing a behavioral health provider to be devoted entirely to the needs of their population. However, currently there are several barriers that make true integration nearly impossible.

4) What is not working well in the BHO system?

- BHOs say they are limited by policies to not be able to provide services for children who have symptoms or abnormal behaviors but no billable diagnosis.

- Children with specialized behavioral health needs, such as children with autism or dually-diagnosed children (those with developmental disabilities and socio-emotional or behavioral disorders) have little or no access to needed services. Or these services are sparse and extremely difficult to access.

- Value Options leadership is made up of the heads of mental health centers, which is a conflict of interest. The BHO function should be moved to the RCCOs and BHOs should be integrated into the RCCOs

- They are involved in separate regions. Regions should be identical to ensure collaboration and improved practices between the efforts for both organizations.

- **Difficulties with credentialing.** This process changes from BHO-to-BHO, is long and tedious, and in some cases, requires behavioral health providers to have worked with Medicaid populations for at least 5 years (?). This alienates a substantial portion of an already too-small workforce. Licensed behavioral health providers already engage in a lengthy process through DORA, in which their credentials and past work experiences are examined and verified. This process should have some consistency amongst BHOs and should be coordinated with other state departments with similar functions.

- **Referral processes.** Care coordination for behavioral health should occur at the practice level. Creating an additional step (by having providers fax referral forms to the BHO) creates an additional barrier for patients/families and practices. When referrals are made, direct contact should be with the local CMHC from the practice.

- **No streamlined processes across BHOs and RCCOs.** Primary care practices have patients and families from multiple counties in their practice at any given time. Having separate policies and procedures for each BHO and RCCO makes it difficult for providers to know how to get assistance when needed. Having one procedure, one contact person, and one phone number would allow BHOs/RCCOs to be more effectively utilized by practices.

- **Access to child psychiatrists.** There is an extreme (and known) shortage of psychiatrists statewide; this becomes increasingly dire when discussing access to child psychiatrists. The CPACK program is currently filling a critical void; but is a grant-funded program in danger of losing funding. BHOs could potentially have a role in helping to provide this much needed access.

5) What is working well with RCCO and BHO collaboration right now?

- Colorado Access RCCO and BHO for RCCO region 5 works better because at least they are housed together and sometimes communicate. This is an example of a good start toward integration of BHOs and RCCOs. However, even CO Access and Access Behavioral Care need to work harder on communicating and coordinating.

6) What is not working well with RCCO and BHO collaboration right now?

- **Little to no communication or coordination between RCCOs and BHOs.** Operating as two completely independent systems. Both systems have their own processes for care coordination, for referrals, and don't seem to communicate as much as is needed. For integrated care to be successful at the practice level, it has to be operating successfully at a systems level. This is one of the biggest issues for integration for the Medicaid population.

- **Duplication of services.** If there was increased communication and alignment between the RCCOs and the BHOs, service duplication could be minimized, there would be cost savings, and it would be easier for patients and families to access services. For example, both BHOs and RCCOs offer care coordination services. In some cases, the local mental health center has also been delegated to provide care coordination. At the practice and provider level, it's often difficult to know which system to access to address a family's needs, particularly if a child has both behavioral health and physical health needs. Resources could be conserved and systems could be more effective if there was one access point for care coordination.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

- **Payment reform.** Though this is a long-term goal, there are things in the short-term that will promote the financial sustainability of integrated care. Open the behavioral health and wellness CPT codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration. Also, in the current BHO rule, there is a covered diagnoses list that is required to bill. This list does not allow a provider to bill for v codes (physical or sexual abuse of a child, neglect of a child, parent-child relational problem, etc.) or other psychosocial or family stressors that are known precursors to mental illness; this is the opposite of a preventative approach and encourages pediatric BH providers to find a diagnosis – when the behavioral presentation is really due to family circumstances. Additionally, one of the goals in recent years for Colorado has been to decrease the number of children taking psychotropic medications. Allowing providers to intervene earlier would have a direct positive impact on that goal. The recommendation would be to allow for the billing of v codes (from

DSM-5) and related psychosocial conditions (as opposed to being diagnosis driven).

- **Financial support of true integration, as opposed to co-location.** This would be another reason that BHOs and RCCOs need to be fully aligned in their payment systems and in other areas – as long as the payment remains siloed, the services will remain siloed. Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

- **Establish a standard of care for integrated BH providers and make the rules/regulations/guidelines accessible and clear.** This also includes credentialing requirements and providing immediate training on the correct use of HIPAA regulations. Any committee or group that is tasked with creating the standard of care of integrated behavioral health providers working in primary care settings should be composed of local clinicians and experts in the area (as opposed to strictly policymakers). This group should also provide guidance on the paperwork and credentialing requirements. All agencies involved in licensing and credentialing for behavioral health professionals (e.g., DORA, OBH) should be present.

- **Provide infrastructure and funding for data collection and management.** Utilizing SDAC data is just one way to understand the activities within a medical home – others are needed. There are currently projects being developed in the state that would utilize other modalities (e.g., IPad technology) to help practices collect data efficiently and effectively at the practice level. There will need to be an investment in the development of these programs and many practices would need financial assistance with implementation. However, this would be a way for practices to track all the activities that the state would like monitor (e.g., screening rates, follow-up, referral) and would allow the practice to improve patient and family care.

- **Support of care coordination activities.** Much of the care coordination will have to be done within the medical home. HCPF needs to be willing to help the integrated behavioral health provider understand how to be reimbursed for the care coordination that they will need to do on behalf of the Medicaid patient.

- **CMHC Policy and procedure change (via the BHO contract).** It is important to recognize the ways in which current policy can be problematic for practices, patients, and families. Currently, the BHO contract requires CMHC's to offer "intakes" or evaluations to patients/families within 7 days of referral from a primary care practice. This sounds reasonable. In theory, there are several complications: 1.) Offering a slot for an intake does not qualify as providing a gold standard of care. It has been frequently reported that time slots offered for intake appointments are typically during the 8-4 workday – this makes a family or patient choose between work and their health (and families are already much less likely to show up for behavioral health appointments). There needs to be increased flexibility in this area. 2.) Also, offering an intake is not the same as providing therapy. Patients or families may come in for intakes and typically wait to be assigned a therapist. Then wait for that assigned therapist to call and schedule an appointment. This could be weeks after an initial referral. This process does not translate to patient- or family- centered care. This is just one example.

- **Sustainability and prevention.** The clear fact remains that if prevention does not become the focus of healthcare (physical and behavioral) costs will continue to skyrocket and our population will continue to develop multiple costly, chronic diseases. Prevention is the key to long-term population health and begins in infancy. So much of the behavioral health work and overall healthcare focus in Colorado has been focused on those that have already developed chronic conditions; ultimately, this does not serve our

population well in the long-term. Population health is a focus of the SIM work and thus, funding and attention must be given to early childhood behavioral health, prevention, and early intervention.

- **Support of current programming and infrastructure, as opposed to creating new duplicate programs.** Colorado is an innovative state in many ways and has already begun this work through the efforts of multiple programs, statewide initiatives, and community organizations. Programs like the CPACK program developed by CBHC address statewide disparities in the availability of child psychiatrists and promote behavioral health integration in primary care. Effort should be channeled into supporting existing effective programming, not creating new infrastructure.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing SDAC data is just one way to understand the activities within a medical home. SDAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients
  b. Telephone consultation by a child psychiatrist to primary care providers
  We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

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behavioral health appointments). There needs to be increased flexibility in this area. 2.) Also, offering an intake is not the same as providing therapy. Patients or families may come in for intakes and typically wait to be assigned a therapist. Then wait for that assigned therapist to call and schedule an appointment. This could be weeks after an initial referral. This process does not translate to patient- or family- centered care. This is just one example.

- **Sustainability and prevention.** The clear fact remains that if prevention does not become the focus of healthcare (physical and behavioral) costs will continue to skyrocket and our population will continue to develop multiple costly, chronic diseases. Prevention is the key to long-term population health and begins in infancy. So much of the behavioral health work and overall healthcare focus in Colorado has been focused on those that have already developed chronic conditions; ultimately, this does not serve our population well in the long-term. Population health is a focus of the SIM work and thus, funding and attention must be given to early childhood behavioral health, prevention, and early intervention.

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8) Barriers to the integration of behavioral health and physical health services. Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	Barrier? No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	The current financial system for CMHC's only supports one form of integration – the co-location of a behavioral health provider that is based at the CMHC. Since funding for CMHC's is strictly determined by the number of "members" served, CMHC's are not currently incentivized to support an integrated behavioral health provider working in a primary care office (that is outside of their system). This can create a feeling of competition between CMHC providers and other integrated BH providers. Yet, in order for our behavioral health system to be successful, we need all providers to coordinate care and work together. There is no simple solution to this – this requires both culture change and payment reform. CMHC's should be provided funding based on community need; many rural or frontier parts of the state are less populated, yet have poorer behavioral health outcomes and need more programs/services. Additionally, CMHC's have practiced in a manner that may discourage coordination with PCP's – demanding multiple releases of information (before even getting on the phone with a PCP – which is NOT mandated by federal HIPAA guidelines) and failing to close the loop once a family has been referred. There needs to be immediate training statewide about the TRUE implications of HIPAA in all the CMHCs; instead of continuing to let it be a barrier to communication between providers. Additionally, each CMHC needs to have a designated person to handle communication and relationships between the CMHC and primary care practices. There needs to be ONE contact person (ideally there would be multiple, depending on the number of practices in the region) and one phone number to call and follow-up on referrals.
Community Behavioral Health Services Rule	☒	☐	If Colorado is serious about integrated care and allowing behavioral health professionals to successfully work alongside physical health providers, the state cannot just apply current behavioral health services rule to integrated care settings. There need to be guidelines for standard of care (for BH providers in integrated care settings) but paperwork requirements, requirements for updating "treatment plans" (which may or may not be relevant in integrated settings), need to reflect the work done by an

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

			integrated BH provider. Not unlike a PCP, an integrated BH provider may see 15 – 20 patients or families a day (in a true integrated model) and so, requiring lengthy intake forms, treatment plans, and other cumbersome paperwork is not required for providing quality care and will add nothing to a patient/family experience. The requirements for integrated BH providers need to be consistent with those required of physical health providers – allowing BHP's to spend more time providing quality clinical care and training (as opposed to doing paperwork).
Covered diagnoses list	☒	☐	Many children do not have a covered diagnosis but need treatment. For the pediatric population, the focus must be prevention and addressing psychosocial, economic, and family stressors BEFORE they develop into full-fledge psychiatric disorders. Investing in prevention among children (particularly those on Medicaid) is the only way to decrease the development of chronic disease in the adult population (which is one of the largest drivers of skyrocketing healthcare costs). The recommendation would be to allow for the billing of v codes (from DSM-5) and related psychosocial conditions (as opposed to being diagnosis driven).
Different behavioral / physical health reimbursement	☒	☐	For the pediatric population, the focus must be prevention and addressing psychosocial, economic, and family stressors BEFORE they develop into full-fledge psychiatric disorders. Investing in prevention among children (particularly those on Medicaid) is the only way to decrease the development of chronic disease in the adult population (which is one of the largest drivers of skyrocketing healthcare costs). The recommendation would be to allow for the billing of v codes (from DSM-5) and related psychosocial conditions (as opposed to being diagnosis driven).
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	Solve the release of information problem between the two different systems so the patient's needs and health are primary not the systems. All done with the patient as the focus. Currently, it's difficult to understand if OBH has any regulatory responsibility to behavioral health providers working within primary care. OBH has traditionally governed 27-65 designated facilities, which (in many cases) does not include primary care settings. This is extremely significant, since OBH provides guidance on documentation requirements, the establishment of treatment plans, crisis procedures, HIPAA regulation, etc. for individuals providing behavioral health and substance abuse services. There needs to be a training

			(by OBH or another identified agency) that clarifies the rules/guidelines for integrated behavioral health providers working within primary care settings. This should be 100% consistent with the requirements for physical health providers; there should not be more paperwork or reporting demands.
PCMP financing structure	☒	☐	
Per-member per-month amount	☒	☐	One of the core components of allowing behavioral health integration to be successful is care coordination. There need to be increased reimbursement levels to allow for care coordination to be completed within the medical home.
Physical space constraints	☒	☐	
Privacy Laws (HIPAA, 42 CFR)	☒	☐	Attorneys tend to give very conservative opinions that are not consistent with HIPPA rules. We need clinicians to describe the documentation methods they This issue needs to be addressed through training – immediately and statewide. Federal HIPPA states that providers can communicate with one another if in the best interest of patient (without a release of information). The only stricter state statute in Colorado (42 CFR) applies only to substance abuse and requires additional permissions. There is nothing stopping behavioral health providers and PCMPs from communicating from a HIPPA perspective (aside from in the case of substance abuse). Needing this many permissions and releases is a myth (primarily perpetuated by behavioral health). Dayna Matthew is a law professor at the University of Colorado Law School who is an expert in this area and also knows the local laws/statutes. She should be consulted and should assist in putting together a training to be disseminated to PCMP's and CMHC's statewide.
Professional / cultural divisions	☒	☐	Though there are practices that have been doing integrated behavioral health for decades, many PCP's and behavioral health providers are unfamiliar with the practice of integrated care. Most have a theoretical understanding of integrated care, but putting it into practice With a little coaching on how to effectively work together, PCMPs and integrated behavioral health providers are able to be successful serving patients and families.
RCCO or BHO contracts	☒	☐	RCCOs and BHOs need to be merged, paid in similar manners, have aligned incentives, coordinate all activities and function as a unit. When the larger systems remain siloed, it is difficult for the community practices and clinics to function in an integrated manner.
Staff capacity	☐	☒	

State/Federal rules or reporting requirements	☒	☐	The Tri-agency Task Force, composed of individuals from multiple state agencies (CDPHE, HCPF, OBH, HHS) and community stakeholders, identified a whole host of policies that are barriers. A detailed report on how to fix those barriers was provided to leadership at HHS. This would be a great place to start.
Technical resources / data sharing	☐	☒	This can be worked out. Utilizing SDAC data is just one way to understand the activities within a medical home – others are needed. There are currently projects being developed in the state that would utilize other modalities (e.g., IPad technology) to help practices collect data efficiently and effectively at the practice level. There will need to be an investment in the development of these programs and many practices would need financial assistance with implementation. However, this would be a way for practices to track all the activities that the state would like monitor (e.g., screening rates, follow-up, referral) and would allow the practice to improve patient and family care.
Training	☒	☐	Integrated behavioral health providers (IBHPs) for children require a very different skill set than IBHPs for adults. The Department of Child Psychiatry at UCDenver and Children's Hospital, along with CCHAP are expanding their training capacities. There is also work being done to develop a training program uniquely geared towards pediatric IBHPs – this is vital to providing effective and high quality care.
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

The American Academy of Child and Adolescent Psychiatrists (AACAP) has identified several components that are vital to providing high quality behavioral health within a pediatric medical home:

- Prevention and screening
- Early Intervention
- Routine assessment and treatment
- Specialty consultation
- Specialized Treatment
- Coordination of services and monitoring

Adapted from the "Best Principles for Integration of Child Psychiatry into the Pediatric Health Home" 2012

This framework is based on key general principles that are aligned with the goals and objectives of multiple professional associations that currently support integrated behavioral health efforts. These principles include family-focused care, professional collaboration, care plan development, and care coordination.

The integrated behavioral health provider (IBHP) in a medical home that serves children on Medicaid should have the following skills:

- A command of child development to guide screening and referral decisions
- Ability to manage many aspects of post-partun depression
- Ability to manage common minor behavior problems in children
- Ability to provide early childhood intervention
- Ability to handle common behavioral issues in school age children, including counseling around ADHD
- Ability to assess and manage or refer adolescent behavioral health issues
- Ability to assess, manage or refer substance abuse issues in children or teens
- Skills in addressing socioeconomic barriers for the whole family
- Ability to oversee care coordination for behavioral health issues for the whole family

10) Please share any other general advice or suggestions you may have about behavioral health integration.

- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients
  b. Telephone consultation by a child psychiatrist
     The training component was not as helpful. We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- There needs to be better reimbursement for behavioral health care in the medical home setting.

- Colorado Medicaid needs to open behavioral health codes (96150 – 96155).

- The BHOs should be integrated with the RCCOs, have the same regions, reduce duplication of efforts and have better alignment of incentives and payment that support integrated care.

- There are many policies that are barriers to integration.

How will the RCCOs support the needed work force development? To integrate you need the expertise with in the practice for identifying need and the folks trained and integrated to meet the need. How are we going to train/help the staff get to the point to support a family and to help them to understand the need they have for services? This issue should be a focus of the next RFP how to train and pay for these services in a sustainable manner.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination? Care Coordination is an organized/structured set of activities to support a patient receiving the appropriate services and resources necessary to achieve the best results necessary. These services are provided in a patient/family centered way which includes assessment of needs and strengths, a developed care plan and goals focused on the family and follow up on activities in the plan to be sure that needs were met or support services provided so that services stay focused on the needs identified by family.

b. How should RCCOs prioritize who receives care coordination first? High on the list need to be referrals from provider and practice staff, patients/families needing high levels of specialty care, premature infants, long term care services and palliative care, children and families needing waivers and children not showing up for their appointments. A request from the patient/family for help should also be considered a high priority.

c. How should RCCOs identify clients and families who need care coordination? We believe the effort and staff hours should go to those patients/families where change can be made such as socioeconomic issues, no show issues, lack of transportation. They should also help with navigating the health care system. Very high utilizers of emergency departments are easily identified as needing care coordination.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider? Monthly activity reports.

12) What services should be coordinated and are there services that should not be a part of care coordination?

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes by assisting families to find resoruces for needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

Need is determined by the patient and family. Care Coordination is basically built on a relationship and that relationship must be developed in a trust-filled, patient-centered, supportive environment.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today? The care coordinators themselves (and the medical home) are not aware of whom else is involved.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different? Takes place in school, non-profit organization, religious organizations, between friends and in families to name a few. These informal and formal relationships need to be supported, coordinated and nurtured. We are looking for results that lead to better lives, not credit for who did something.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships? Allow providers to help patients and families and intervene to support the work closest to the patient and in the patient/families community. RCCO centric care coordination is distant for the patient/family and not in tune with the system that the patient/family currently functions.

d. What are the gaps in care coordination across the continuum of care? There is a lack of understanding particular systems and a lack of relationship in the non-delegated system being created. It has lost its personal touch in most instances. In

the pediatric system, there are gaps in hospital to community, particular for preemie babies, interaction with schools and day care, developmental screening and treatment, transportation support, health literacy, and transition to adulthood. All vital for the successful growth of children.

15) RCCOs' roles in addressing clients' and their families' non-medical needs. Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☐	Reporting abuse and neglect, both child and elder and supporting the investigating agencies and helping with needed services not being provided by another agency.
Affordability (assistance with prescriptions or co-pays)	☒	☐	☐	Don't assist everyone, but have resources so that needed help can be obtained and the provider's identified services can be received. Help families find resources and document that the family was actually helped.
Daycare / childcare	☒	☐	☐	Help families find resources and document that the family was actually helped.
Economic stability & employment	☒	☐	☐	Help families find resources and document that the family was actually helped.
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☒	☐	☐	Help families find resources and document that the family was actually helped.
Health literacy	☒	☐	☐	Help families find resources and document that the family was actually helped. Have RCCOs take responsibility for finding good training for providers and staff on this topic.

Housing	☒	☐	☐	Help families find resources and document that the family was actually helped.
Language or translation services	☒	☐	☐	Help families find resources and document that the family was actually helped. RCCOs should support practices with easy and inexpensive ways to obtain immediate interpretation and translation of documents.
Literacy	☒	☐	☐	Help families find resources and document that the family was actually helped.
Transportation	☒	☐	☐	Help families find resources and document that the family was actually helped. Make sure that resources are available in all areas of the RCCO.
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) Requirements about who should be doing care coordination. Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

- **In answering the following question, we are assuming that care coordination is being done in the medical home**

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☒	
Certified Addiction Councilors	☐	☒	
Certified Nurse Midwives	☒	☐	In OB Gyn office only
Community Health Workers	☒	☐	For most Medicaid recipients. Practical feet on the ground; health literacy helpers; follow up; know neighborhood and community resources
Generalists (BA/BS/MA/MS)	☒	☐	For most Medicaid recipients. Best choice; know alittle about a lot, good problem solvers
Health Coaches	☐	☐	

Licensed Clinical Social Workers	☒	☐	For highly complex social situations or complicated mental health clients. Possibly for supervision; can also do behavioral health, grief/loss and palliative care.
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☒	☐	For complicated mental health clients. Need to be generalist good at all ages
Licensed Professional Counselor	☒	☐	For complicated mental health clients. See above
Masters of Public Health	☐	☒	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☒	
Nurse Practitioners	☐	☒	
Patient Navigators	☒	☐	For most Medicaid recipients. Can provide very practical information to patients, help with health literacy, know area
Peer Advocates	☒	☐	For most Medicaid recipients. Can help with practical information on community; can make calls and set up appointments
Promotoras	☒	☐	For most Medicaid recipients
Psychiatrists	☐	☒	
Psychologists	☒	☐	For complicated mental health clients
Registered Nurses	☒	☐	For medically complicated complex clients. Doing this work now
Social Workers	☒	☐	For clients with very complicated social issues
Wraparound facilitators	☐	☐	We don't know what these are, but might be like Peer Advocates.
Other	Please type your response here.		

17) Care coordination requirements for specific populations. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☐	Preemies, born with equipment needs, O2, genetic abnormalities
Children	☒	☐	Need special training regarding care coordination for children (which CCHAP can provide). Genetic abnormalities, need equipment, blind, hearing loss, developmental delays, foster care.
Children who are healthy, but in socially-complex environments	☒	☐	Need special training regarding care coordination for children (which CCHAP can provide). Legal, parental and behavioral issues as well as all the developmental issues of children and teens need special care and knowledge.
Children involved in the foster care system	☒	☐	Need special training regarding care coordination for children (which CCHAP can provide). Legal, parental and behavioral issues as well as ll the developmental issues of children and ttens need special car e and knowledge.
Children with a chronic illness	☒	☐	Special knowledge of complex medical conditions, waivers, equipment, respite is necessary.
Children with a serious emotional disturbance	☒	☐	Need special training regarding care coordination for children (which CCHAP can provide). Considered complex care need to understand needs of child and family.
Children with medical complexity	☒	☐	Need special training regarding care coordination for children (which CCHAP can provide. Needs to be a nurse providing the care coordination
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	Need special training regarding care coordination for children (which CCHAP can provide). See above in emotional disturbance.

Transition-age adolescents	☒	☐	Persuading adult providers is hard.
Parents and families	☒	☐	Need to understand family dynamics
Pregnant women	☒	☐	Complicated medical situation
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

Working in a collaborative mode with anyone connected with the patient. RCCO staff will need to learn about the legal and temporary nature of foster care and residential care and support schools; behavioral health and physicians in helping the child receiving care to have a good care plan and make sure that plan follows the patient

19) How should care coordination be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate

for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

There should be the development of process and clinical outcomes the show that care is happening. The measurements should be the same for RCCOs and for medical homes that have been delegated to do care coordiantionby the RCCO.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services? We believe there should be a basic payment for care coordination. This would cover the cost for monitoring, data support, and "being ready for anything. Cost $5-6 PMPM at the medical home level, which is where care coordination should be done.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population? Yes. Complex medical and social situations need more time, possibly travel and much more clinical knowledge to ensure positive outcomes. Cost $6+ PMPM for high CRG patients and families.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population? YES

a. Care coordinator to client ratios. If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☒
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐

2,001-3,000	☐
3,001-4,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

Measurement will have to start with process outcomes, but as folks become more proficient outcomes could be decreased no shows, patient satisfaction, use of community resources, care plans completed, increase immunization rates, proportion of patients receiving well cild visits.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

- Care coordination is best done in the medical home by members of the medical home team. Care coordination done from a call center in the RCCO tends to be superficial, only partially meet the needs of the patient and family, is fragmented (often fails to close the loop, i.e. follow through to be sure problems were satisfactorily met). The next best solution is for care coordination to be provided by community-based organizations set up to provide specific types of care coordination or care coordination for certain types of populations (ethnic group or chronic illness-specific groups). In this case, there must be direct bi-directional communication with the medical home. The least satisfactory care coordination is from a call center in the RCCO.

- Many medical homes relate to multiple RCCOs and they want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, they could receive a pmpm from all of them, which would enable them to afford to hire enough care coordinators to meet the needs of all of their ACC patients.

- Medical homes are willing to do care coordination, because they have a relationship with their patients. They trust them. Coordinating complex medical care is essential for good care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

- The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- On a regular basis, RCCOs should share the RCCO's performance on KPIs, share savings incentives and share with the medical home how their own performance compares with other medical homes.

- Functions: No function of a RCCO should look different from one RCCO to another from the perspective of the customer, specialists, providers, patients, and families moving from one place to another. If the service touches a customer it MUST look and feel the same such as accessing services, contacting services, receiving services. Internally RCCOs can be different, but a customer should never hear "that is not my practice, we don't do that, or you will have to call this number."

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

All RCCOs should have their offices in the region served, should be non-profits and be incorporated only in Colorado.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

- This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region.

- The first RFP was looking for different approaches from the different RCCOs. Now, we think uniformity would be more important and the basics of administration and service provision should be mandated by HCPF and all RCCOs adhere it.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County.

- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the

same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

Improve attribution, decrease the time lag for data (not four months behind) , provide for the ability to pull reports on particular topics. Stop making changes that the medical homes have to make. Allow them some time to catch up with current expectations.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

- There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

- Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

- The attribution system continues to be flawed and the process of getting patients re-attributed to the correct medical homes is still very onerous. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- In the RFP, ask RCCOs how they can help improve processes for correct attribution and simple, easy correction of mis-attribution.

- Hold more patient/parent/family client focus groups.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

- The RCCOs all do things very differently which is confusing for medical homes with patients in several RCCOs. RCCOs. RCCOs are very inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). And they are very variable from one RCCO to another. So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and response to requests for help more consistent.

- Feedback from RCCOs regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and was there improvement?

- And there are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Maintain Advisory groups, but use them for advice instead of reporting activities to them. These groups must be active participants and their view points be seen supportive and helpful. They may have ideas to make the program better. Use these folks as subject experts and advisors instead of once a quarter meeting attenders.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population? NO

a. If no, what are the gaps?

   Hospitals are not participating. They all must participate to make this effort work successfully.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities. Children and their families are not a sub population, but currently are being treated that way. The emphasis has been going to "where the money is" to keep the RCCO functioning. If you want to put an emphasis on whole person preventative care, look at your youngest members and don't think of them as a sub-population. They are the majority of your members.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

Hospitals should be incented to communicate better with medical homes. They should have significant financial disincentives to see Medicaid patients with minor problems in their emergency departments.

b. What role should pharmacies play in the next iteration of the ACC Program?

Pharmacies should be rewarded for arranging training for their pharmacists and technicians in cross-cultural communication, providing translation services and providing extra teaching for families with limited health literacy.

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

The Healthy Communities personnel should be functionally merged with the RCCOs to enable better coordination and reduce duplication of efforts

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

Should be done in the practices part of the Care Coordination iand the PMPM should be sufficient to support it.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

No, if we provide Care Coordination at the practice level, the practice needs to decide how is is going to do that. CHWs are a good choice if paired with others. PMPM should be enough to defray the expenses of CHW.

47) Community Health Worker reimbursement. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

- Maintain accurate up-to-date listings of dental providers accepting Medicaid.
- Assist dentists in applying for Medicaid credentials

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

The Joint Commission has identified the following 3 challenges as the "triple threat" to healthcare communication: 1. Language barriers 2. Cultural barriers, 3. Low health literacy barriers.

b. What RCCO requirements would ensure cultural competency?

RCCOs should contract for training for their staff and the personnel in medical homes to receive training regarding:

- Cultural barriers to good health outcomes and how to address them
- Cross-cultural communication
- Addressing limited English proficiency in clients
- Addressing limited health literacy
- Each RCCO must have a comprehensive strategy to address effective communication (oral and written) with limited English and culturally different patients/families as well as those with low health literacy.
- What is your "organization's" strategy for addressing the triple threat on these three levels:
  - Building awareness of the "triple threat" to healthcare communication (1, 2, and 3 listed above)
  - Identifying and addressing systemic solutions to health literacy (signage, website readability, handouts, phone trees, communications to patients, care coordination).
  - Implementing education/training for providers and staff in private practice and clinic settings in your region to improve communications skills that lead to better health outcomes for all patients.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

- Understanding Cultural barriers to good health outcomes and how to address them
- Cross-cultural communication
- Addressing limited English proficiency in clients
- Addressing limited health literacy

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

- Pay medical homes even higher reimbursement for after-hours care than you do now.
- Pay emergency departments at a lower rate than medical homes for patients with minor problems.
- Require co-pays even for children. But waive the co-pay if they called their medical home first.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) Support for practices. Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐

Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☒	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐

Others	Nurse line – the Medicaid nurse line number is on Medicaid cards. The Medicaid line does not communicate with the medical home about calls or referrals to emergency departments. The Medicaid nurse line undercuts the medical home. The patient should call their medical home. There are so many programs being funded to provide practice support, SIM, CHES and now TCPI, I believe the question is not what to provide, but how does the ACC fit into what is available to practices and not flood the practices with helpers from each for these initiatives. How can the programs work in collaboration with a single goal in mind and split up the work? All the tools and supports are great, but the process of helping practices will not be welcomed if the program look uncoordinated and non-collaborative. Let's work together.

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

See Above

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

- The current "Enhanced Medical Home Standards" and the well child visit KPI are sufficient.
- The more incentives, the less of an incentive they create.
- A pmpm is also ok; but attribution is very flawed which serves as a disincentive

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

Shouldn't be required, because it could be expensive for the small medical home and would likely require double entry of information. So, it could be recommended and incented. HCPF or RCCO would probably have t provide registries for smaller medical homes that are compatible with the medical home's EHR.

58) Please share any other advice or suggestions about provider support in the ACC.

The ACC is headed toward capitation. It would be important for HCPF to open codes now to encourage services and activities you want medical homes to provide later under capitation, so medical homes establish the habits now and so frequency of the services and fair reimbursement can be determined prior to switching to capitation. For example, social-emotional screening in toddlers and preschoolers should be reimbursed now.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

- Since children are the majority and give the best chance of truly improving health and wellness, KPIs need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully. Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state should already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it moves to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

RCCOs should be sure that medical homes that meet their key performance measures or other targets should receive their full share of incentive payment even when the RCCO as a whole has not met its performance targets.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and provider from medical homes to develop a vetting process that will enable HCPF and RCCOs to trust medical home self-reported real-time data.

- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd. Appropriate child health measures could be selected from the following measures :
    - Well child visits appropriate for age
    - Developmental screening by three years of age
    - Teen depression screening
    - Complete immunization status by age two
    - Post-partum depression screening rate for mothers of newborns by age 4 months
    - Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
    - Patient (or family) satisfaction ratings
    - Documentation of QI projects

- Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate

outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

66) Measuring Client experience. Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and provider from medical homes to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd.

- The following measures should be used to measure outcomes for children:
  - Well child visits appropriate for age
  - Developmental screening
  - Teen depression screening
  - Complete immunization status by age two
  - Post-partum depression screening rate for mothers of newborns by age 4 months.
  - Appropriate antibiotic use in URI and strep pharyngitis

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

The PCMP or medical home should receive real-time data (less than a month since date of service) that will allow them to compare their performance with performance of similar type of medical home.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and

wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☒
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Because many medical homes have patients in more than one region, the KPIs should be the same for all regions. The RCCOs and the PCMPs should have the same KPIs. The medical home should receive incentive payments for reaching its targets even if the RCCO did not reach its target KPIs.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Both. The best incentives are those that give health care providers targets to shoot for AND reward progress

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

Real time data that is accurate is crucial for rapid cycle quality improvement in medical homes and in order to provide incentives that will motivate medical homes. This means data available within 2-4 weeks rather than 4-6+ months. The SDAC data comes too late to: (1) support rapid cycle quality improvement and comes too late to provide meaningful incentives. Both family practices and pediatric practices report that the SDAC is still inaccurate compared to the medical homes own data that they obtain from their EHR, or their claims-based data. Many medical homes these days are able to capture the data needed by HCPF and the RCCOs within a week or two of service, rather than 4+ months later. We recommend that the ACC develop a process for self reporting of data. We realize that HCPF would need to vet the quality and accuracy of practice data, but please consider this.

74) Incentive payment frequency. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) Types of communication. For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☒
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☐	☒
Smartphone app	☐	☒
Other: ALL formats are necessary to address specific needs that the other formats cannot; that's why they're there.		

78) HIT investments by organizations. For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐

Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) Importance of technology by type. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☒	☐	☐	☐
Care management tool	☐	☐	☒	☐	☐
Care transitions alerts	☒	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☒	☐	☐	☐	☐
Health risk assessment software	☐	☒	☐	☐	☒
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☒

Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☒
Patient education wellness tools	☐	☐	☒	☐	☐
Provider/case manager directory	☐	☒	☐	☐	☐
Shared decision-making tools	☐	☒	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☒
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

- Technology to improve the performance of Primary Care Practices
- Possessing outdated tech (eg Windows XP, Office 2003), or next-to-no tech at all
- Inability to use basic office management software (ie MS Office)
- The Attribution algorithm is faulty; FIX IT. KEEP ADULTS OUT OF PEDIATRIC PRACTICES
- Liability anxieties create inter-agency barriers related to sharing PHI
- Releases are not standardized across Medicaid entities.

81) How can Health Information Technology support Behavioral Health Integration?

- Systems are needed for tracking
- Improving assessment and identification of needs that lead to/exacerbate behavioral health issues
- Reducing duplication of work; increasing real-time connections between providers
- Improving security, enhancing communication, reducing cost, increasing user satisfaction

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

YES. Needs to have more data and greater end-user flexibility. It should allow end-user customization to accommodate diverse needs

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

YES. System could be similar to BUS, TRAILS, EPIC, etc. Standardization is VITAL to ensure consistency across providers, regions, and to improve audit efficiency

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

Standardization is VITAL to ensure consistency across providers, regions, and to improve audit efficiency

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

- Require HCPF to include more data and end-user functionality in the SDAC.

- Update ALL data every month (disregard 120-day timely filing delay).
- Make HCPF fix the attribution algorithm; incorporate pediatric practice information to eliminate attribution of adults to pediatric rosters.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

- Standardized, regular, ADT info from hospitals

- Standardized ROI for use by all Medicaid entities.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

- Assistance (one-on-one, classes, over-the-phone, web-based) on using parts of the SDAC; post TREO's SDAC webinar
- Education, consultation on encryption, transmission, and storage of PHI

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

- Sharing of real-time ADT data
- Need to include small and single-provider practices as well

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

"No Practice Left Behind"
Many providers lack the skills to implement anything but the simplest of electronic activities. Population health management involves use of technology that many (most?) do not possess. RCCO's are well-placed to help the providers in their areas improve, as a group, toward more effective population management.

Colorado Department of
Health Care Policy and Financing

Serial # 086

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Mental Health Partners
Location: Boulder, Boulder County, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Click here to enter text.
Location: City, County, State.
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
X Medical provider / PCMP / other provider
  i. Type or specialty: community mental health center
  ii. Area of practice: mental health and substance abuse
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

X Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
X 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:

MHP is a partner/provider and part owner in Foothills Behavioral Health Partners, the Behavioral Health Organization that manages the Medicaid behavioral health capitation contract for the metro west region. FBHP works collaboratively with the RCCO in our area, Colorado Community Health Alliance, to integrate, coordinate and improve health care services to the Medicaid members in our region. MHP is a part of that work and staff of both MHP and CCHA meet regularly to further these goals. MHP is currently working with CCHA on the program focused on Medicare/Medicaid eligibles. MHP provides integrated behavioral health services at current RCCO PCMP clinics, including behavioral health coordination and tele-health services. The integrated care model provided by the partnership between MHP and Clinica Family Health Services is a mature, Level 6 model, with MHP clinicians working as an integral part of Clinica's primary care teams. MHP also has integrated services with other primary care practices that serve both Medicaid and commercially insured patients.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

MHP is a co-owner of Foothill Behavioral Health Partners, the BHO in this region. We are the contracted community behavioral health center

provider for Boulder and Broomfield counties. MHP has a long history of serving Medicaid eligible individuals and families.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

X Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Providing mental health services to the Medicaid eligible population in the counties we serve is a core component of our mission. We have the broad continuum of services essential to meeting the needs of this population, including services that focus on wellness, prevention and the social determinants of health, consistent with the ACC focus on health and wellness. As evidence of this commitment, MHP has recently opened our model for a person-centered healthcare home that incorporates a broad array of psychosocial rehabilitation services as well as a medical center that includes psychiatry, primary care, oral health and nursing services.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

It is to the department's credit that the ACC's intent is to improve healthcare and meet triple aim goals in Colorado. The ACC has created opportunity to expand focus on integration, care coordination and care transitions and to pilot new payment structures. It has furthered the development of patient-centered

healthcare homes and supported the strengthening of relationships between physical health/RCCOs and behavioral health/BHOs.

2) What is not working well in the ACC Program?

Per-member per-month payments are not a particularly robust care management tool. A risk-based, global payment model with clear performance expectations and aligned incentives between payers and providers offers a much more powerful approach to achieving the goals outlined for the evolution of the ACC.

The ACC will achieve health outcomes and ensure savings only if the identification and management of patient populations through clinical information systems and measurement-based care, including automated linkages to community resources, is in place. Coordination of care does not translate to full continuum of care. The ACC is very primary care centric and would benefit from capitalizing on the value of other kinds of healthcare homes, like community mental health centers. The ACC gives care coordination a lighter touch than MHP does for example. By providing care coordination close to the patient and the patient's treatment, the coordination is seamlessly linked to treatment. Care coordination works best when it happens as close to the patient as possible and when it is conducted by people who have extensive knowledge of the community surrounding the patient. There's a lack of clarity around care coordination roles, responsibility and exactly what constitutes the proper level of care coordination. Mental health centers have been doing chronic condition management since the inception of the Medicaid mental health capitation program and have skills to bring to this endeavor.

Human services and public health organizations need to be more involved in the ACC/RCCO model.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

Prior to the inception of the Medicaid mental health capitation program, over 50% of Medicaid dollars were spent on inpatient care; by 2007, as a result of managing care and investing in community-based services by the BHOs and providers, that percentage was reduced to 7%. The program has aligned incentives between payers and providers and shifted the treatment paradigm to community-based, recovery-oriented, person-centered services that focus on the triple aim. The risk-based global payment model provides a more flexible revenue source leading to an ability to provide services that are difficult to reimburse in a fee-for-service payment model. These services include prevention and wellness services designed to focus on health, resilience, self-management of illness, etc. The program also defines performance expectations but leaves room for local decision-making around the types of services and programs that will be effective in meeting those expectations. The BHO/CMHC/MSO system is continually working on innovative delivery system and services improvement in line with the direction of healthcare policy.

BHO providers offer unparalleled mental health and substance abuse services. The comprehensiveness of the continuum of care provided and the populations served at community behavioral health centers, including MHP, best meets the needs of the community. Services for the seriously mentally ill are cost-effective and save the State money. We serve people in the community and keep them out of higher-cost residential care and hospitalization. We collaborate effectively with human services (child welfare, criminal

justice, etc) and with local FQHCs. Global payment models support this kind of coordination and integration.

4) What is not working well in the BHO system?

As is already widely acknowledged, we need a more comprehensive and robust substance abuse benefit.

The BHO has difficulty communicating outside the system because of stricter privacy regulations than those found in physical healthcare. Restrictions around sharing of substance use information are even greater.

These stricter regulations around information sharing, as well as other more burdensome regulations in behavioral health, create obstacles to integration and add cost without adding value.

5) What is working well with RCCO and BHO collaboration right now?

The RCCOs and BHOs are working together to recognize the mental health centers as healthcare homes. They have also worked out ways to share data and to use it to improve patient care. The state is encouraging collaboration, which is an important first step. Some RCCOs and BHOs/CMHCs are moving beyond care coordination to focus on integration and population health.

6) What is not working well with RCCO and BHO collaboration right now?

The limited funding for care coordination services is an issue. The lack of clarity around responsibilities is also an issue. As stated previously, care coordination and collaboration is most effective when provided as close to care as possible and taps the existing relationships and the deep and broad knowledge of multiple healthcare and human services organizations. This is more characteristic of the BHO system than it is of the RCCO system currently.

An effort to determine financial reimbursement models that support integration and collaboration must be undertaken. Models such as bundled payments, pay-for-performance and gain-sharing are viable options; these models will advance the current relationship. Local culture and local practice are essential elements and will influence the partnership. Understanding the local culture and leveraging local relationships to address social determinants is critical for achieving the triple aim and for the successful creation of incentives that encourage favorable and measurable outcomes.

It's important to remember that *core coordinotion* is not *integrotion*. In fact coordination is a very early developmental step in actual integration of physical, mental, addictions, and oral health. The BHOs, given their longer history and developmental arc and their more robust payment model and aligned incentives, are farther along in working towards true integration than the current care coordination emphasis in the RCCOs.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

The top priority needs to be the payment form. An equitable funding mechanism that reflects the respective value of services provided needs to be in place . From a behavioral health standpoint, the mechanism would be a global payment system or potentially a full PMPM (per-member per-month) allocation that accurately reflects value and a shared risks-shared savings approach. A lack of understanding and appreciation may exist for the underlying behavioral health conditions that impact medical costs. Those costs, as well as savings accrued in physical health from behavioral health interventions, need to be clearly understood before a blended payment system is put into place.

Additionally, clinical best practices need clarification for the integration of physical, mental, dental and substance abuse services to be successful. Integration would be better supported—and collaborative care facilitated—if an alignment of payment allowed for the joint provision of behavioral and medical care. Optimally, the model would include payment for an exam room consultation. The ability to bill and code small time increments to capture short consults and check-in interactions would also be beneficial.

Alignment of regulations is a third concern. Our documentation standards are more onerous than the rest of healthcare; this area needs alignment with other providers.

Information exchanges would improve coordination across all providers, mental health and physical health.

Lastly, integration efforts should address prevention in mental health. Intervening at the first signs of a possible need, ahead of a formal diagnosis, could catch an issue early and possibly prevent the development of a more serious situation.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	X		The Medicaid mental health capitation program has been successful in helping Colorado improve care, care experience and cost of care. Payers (BHOs) and providers (CMHCs and others) have been aligned in working toward triple aim goals and supporting innovation. At the same time, funding streams are fragmented, spread across different state departments and mis-aligned, with some based on fee-for-service models that are inadequate and ineffective. There is concern that the success obtained from the Medicaid capitation program could be displaced under the RCCO initiative.
Community Behavioral Health Services Rule	X	☐	
Covered diagnoses list	X	☐	The list doesn't allow for preventive care, sub-clinical conditions or behavioral management of chronic medical conditions. Some diagnoses that can benefit from behavioral health intervention are not included in the list. The list unnecessarily restricts important activities in an integrated setting, including wellness activities or early interventions around social determinants that can help prevent more expensive problems from developing.
Different behavioral / physical health reimbursement	X	☐	
Institutions for Mental Diseases exclusion	☐		
OBH rules, reporting, or financing (regulatory differences between agencies)	X	☐	Working with 2 different reporting and regulatory agencies is onerous. There are documentation issues. Rules and regulations governing behavioral health are more burdensome, which impairs the ability of behavioral health providers to work at the pace of a primary care practice.
PCMP financing structure	X	☐	The financing structure for mental health and substance abuse under PCMP is not

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

			clear.
Per-member per-month amount	X	☐	Currently substance abuse is greatly underfunded; it's unclear what the financing structure would be if substance abuse and physical health were combined.
Physical space constraints	X	☐	Often there isn't the physical space in primary care to incorporate the behavioral health provider.
Privacy Laws (HIPAA, 42 CFR)	X	☐	Difficulties exist with coordination of care, especially around substance abuse. There's a huge barrier in the documentation of medical records (what we can document and what we can report).
Professional / cultural divisions	X	☐	These are workable, but need intentional focus.
RCCO or BHO contracts	☐		
Staff capacity	X	☐	Maintaining adequate staffing is extremely challenging given the number of national and state healthcare reform initiatives; we face continuous salary pressure in the recruitment and hiring of new providers. Bilingual staff are particularly difficult to recruit. Ongoing training is expensive.
State/Federal rules or reporting requirements	X	☐	Alignment would create less complication; we recommend a uniform report.
Technical resources / data sharing	X	☐	The need for multiple releases and the difficulty in charting or sharing information are issues. Care is provided when and where it's needed only when the mental health provider is in the same physical space. Federal privacy constraints impede data sharing.
Training	X	☐	Integrated care is a specialty that requires training.
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

A shared care plan between behavioral and medical health, including substance abuse, is necessary. Optimally, providers share the same location; at the least, they are on the primary care team. Whole-person assessments are critical; patients need to be screened for physical, mental, addictions and oral health issues. The availability and/or access to both physical and mental health must include care coordination and system navigation.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Integration often fails due to lack of funding once a pilot program concludes. The best way to support integration is with a global payment structure that allows greater flexibility in the use of resources. Mental health capitation is effective in supporting quality and cost effectiveness. The State has been focused on bringing behavioral health into the ACC system, a system that is still evolving and is at very early stages of integration and of managing care. The State could leverage the success of the mental health capitation contract by recognizing community behavioral health providers as PCMPs and moving all of the behavioral and physical healthcare needs of the seriously mentally ill under a global payment model managed by the BHOs. Start with a pilot for a limited set of high-needs folks and impact one of your most distressed populations. This creates a platform for extending that pilot into complex condition management, by mental health centers that have long experience in managing complex chronic conditions, for a broader population who have co-morbidities, perhaps using Wagner's chronic care model. Success in these high cost areas can then be scaled to populations without chronic complexities.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination? *"The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care."* (AHRQ, *Closing the Quality Gap)* We would add the element mentioned below about ensuring linkage to all resources necessary for care to comprehensive.

We prefer the term care management; it implies a more proactive and comprehensive approach to managing the care of a defined patient population. Care coordination, or care management, entails providing the linkage to services and/or resources as well as the facilitation of effectively accessing and utilizing those services and/or resources. For example, a patient may need help finding a primary care provider, making the appointment and mapping out the bus route to the provider. That patient may also need to be accompanied to the first appointment to build the skills necessary to achieve maximum independence, which is the long-term goal of care coordination.

b. How should RCCOs prioritize who receives care coordination first?

We recommend prioritizing according to the level of integration, with the most impact in terms of overall cost realization. An individual's level of need, the complexity of their disorder and their level of functioning are also considerations in determining who receives priority.

c. How should RCCOs identify clients and families who need care coordination?

We recommend identifying clients and families by utilization first and cost secondarily, with a comprehensive understanding of what those both entail. Recognize that behavioral health, substance abuse and social determinants greatly impact costs.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

It depends on whether the care coordination is specific to the care being delivered by that medical provider or if it's a more generalized level of care coordination. Care coordination is best handled by the primary medical provider/healthcare home and not by a RCCO. A RCCO can provide care coordination support but not necessarily the actual care coordination The barriers around sharing information make the tracking of care coordination difficult. Efforts are being made to design an electronic record that would be shared by all providers.

12) What services should be coordinated and are there services that should not be a part of care coordination?

Physical, mental, substance abuse and oral health services as well as serious disease management need to be coordinated. Prevention services, including wellness initiatives, health education and transition of care coordination are needed. We're constrained by Medicaid's medically necessary standard. Providers who provide services outside of that standard are not reimbursed. That needs to be fixed. We are further constrained by Medicaid's covered diagnosis and covered service requirements, which mean that prevention and wellness activities are not reimbursed.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

Utilization of services, diagnoses, medications and social determinants are most important. A comprehensive assessment of social determinants, in combination with the medical assessment, determine the level of care coordination needed by the patient. These factors may be stand-ins for a level of risk assessment.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

Typically the primary clinician or case manager is coordinating a patient's care. In other cases, the FQHCs have care coordinators. MHP has care coordinators. RCCO and hospitals have care coordinators. Local governmental and non-profit organizations frequently have care coordinators, e.g. family resource centers, homeless services agencies, aging services agencies, etc. This multitude of coordinators creates fragmentation, inefficiency and too much stepping on toes.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

See 14) a. It isn't totally clear how care coordination provided by different agencies is different. All likely seek to provide comprehensive connection to resources, with some specific expertise in areas most related to the organization's mission. For example, a homeless serving agency may have more knowledge and expertise in housing resources, a food pantry in food resources, others in benefit acquisition, etc. Care coordination that occurs at community mental health centers provides coordination that is more geared to the specific needs and complexities related to individuals with mental health and substance use challenges. For example, housing resources that will be more tolerant to some behaviors that others might see as problematic or offering more support in completing applications for benefits, etc. People with behavioral health issues also may have criminal charges related to their illness; mental health providers incorporate this knowledge into care coordination approaches. MHP also partners with local agencies by providing on-site staff to work with the agencies' clients, including providing recovery care coordinators in housing sites in order to support retention of housing. MHP

coordination tends to be more comprehensive, more intensive and longer-lasting than what occurs at the ACC level.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

When the ACC contracts with a PCMP, a determination should be made if the PCMP has sufficient volume to have care coordination on-site, working as a part of their primary care team. This is the ideal situation since care coordination is most effective when it is provided as close to the care as possible. The ACC can focus on supporting care coordination at lower volume PCMPs, which may also be more likely to serve lower need/risk patients, where care coordination from a distance might make more sense. For PCMPs where care coordination is provided on-site, the ACC could focus on offering technical assistance and a higher level of support when resources at the local level are exhausted and gaps remain. Care coordination for complex chronic conditions (where co-morbidities typically exist) needs to happen at the local provider level. This is characteristic of a significant number of people served at community mental health centers and other safety net providers and illustrates why community mental health centers need to be recognized as PCMPs. Local providers are more likely to be successful in preventing duplication of care coordination than the ACC/RCCO would be. This issue illustrates why human services and public health agencies need to be involved in the ACC.

d. What are the gaps in care coordination across the continuum of care?

The difficulty in communicating with providers and families due to the multiple releases required by Colorado law creates a gap in care coordination. A gap in care coordination exists between substance abuse and the rest of the system. A gap exists between hospital health systems and community providers and between hospitals and their communities. There are also gaps in care coordination related to social determinants of health, e.g. housing and food stability, domestic violence, child abuse and neglect, etc.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	X	☐	X	
Affordability (assistance with prescriptions or co-pays)	X	☐	X	

Daycare / childcare	X	☐	X	
Economic stability & employment	X	☐	X	
Education	X	☐	X	
Environment	X	☐	X	
Food access / nutrition	X	☐	X	
Health literacy	X	☐	X	
Housing	X	☐	X	
Language or translation services	X	☐	X	
Literacy	X	☐	X	
Transportation	X	☐	X	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☐	There's no one on this list who couldn't do care coordination—care coordination is in their scope of work—but care coordination is not the best use of their time and skill set.
Certified Addiction Councilors		☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	

Generalists (BA/BS/MA/MS)	X	☐	
Health Coaches	X	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	X	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	X	☐	
Peer Advocates	X	☐	
Promotoras	X	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	X	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations**. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	X	☐	General requirements apply and each of these populations has unique needs, resources and funding streams.
Children	X	☐	
Children who are healthy, but in socially-complex environments	X	☐	
Children involved in the foster care	X	☐	

system			
Children with a chronic illness	X	☐	
Children with a serious emotional disturbance	X	☐	
Children with medical complexity	X	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	X	☐	
Transition-age adolescents	X	☐	
Parents and families	X	☐	
Pregnant women	X	☐	
Adults	X	☐	
Adults who are healthy, but in socially-complex situations	X	☐	
Adults with a chronic illness	X	☐	
Adults with a behavioral health diagnosis or substance use disorder	X	☐	
Clients involved in the criminal justice system	X	☐	
Clients with a disability	X	☐	
Clients in a nursing facility	X	☐	
Elderly clients	X	☐	
Frail elderly clients	X	☐	
Clients in palliative care	X	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

This is included in care management responsibilities. Maintain those relationships and understand the specific medical and social needs of those children. Perhaps focus on supporting role of the most appropriate healthcare home (PCP, mental health or specialty provider) in conjunction with human services for children involved in foster care.

19) How should care coordination be evaluated? How should its outcomes be measured? We recommend benchmarking utilization and cost against previous timeframes or state and national metrics. Qualitative outcomes can be measured at both the provider and the patient level.

Care Coordination should be evaluated based on its ability to improve health outcomes, care experience and cost for the individual. This allows care coordination to directly link to improving the value of healthcare services for the individual. This involves direct self-reported patient measures combined with health outcome and cost data at the individual level. These measures should include

measures of self-management/self-efficacy (e.g., the Patient Activation Measure) and successful linkage(s).

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

    a. What is the PMPM cost for providing care coordination services?

       This cost is dependent upon the level of care coordination being provided. An estimate of risk needs to be built into the PMPM formula.

    b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

       Varying PMPM across populations may or may not be effective as some populations will be at higher risk than others.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

    No, we don't recommend it. The contractor is responsible for outcomes. The State shouldn't try to micro-manage how contractors achieve those outcomes.

    a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

The Department needs to look at the effectiveness of care coordination activities in contributing to improved health, better care experience and overall cost of care.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

We agree with data reporting. Most important is the ability to report data that allow for statewide comparisons. We need clear data definitions so the data mean the same thing across entities.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

There should be minimum expectations of actions to engage and collaborate with essential community providers, including those whose focus is on social determinants of health. A bidder should be required to conduct a comprehensive community needs assessment during year one of their contract. The assessment needs to focus on identifying gaps and health needs, followed by a plan that addresses the findings.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes, the region maps should change. RCCOs and BHOs should be aligned across the state. It's difficult to provide integrated care when they don't align. Broader is better (tiny areas create difficulty for people receiving care).

28) Should the BHO region maps change? Why or why not? If so, how?

Yes (see #27)

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

Allowing mental health providers to bill for behavioral medicine services and fully funding the substance abuse benefit will increase the effectiveness of the ACC. Decrease administrative burden of behavioral health providers. Align documentation and reporting requirements. Seek changes in regulations regarding information sharing.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

The current substance abuse benefit is very limited. Inflexibility in focus on covered service and covered diagnosis which prevents reimbursement for prevention and early intervention and wellness.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

RCCOs should provide clients with options and facilitate clients in selecting their PCMPs. RCCOs should not attribute them.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

They should develop a collaborative approach to prevention and population health management, including desired outcomes and shared goals. The ACC program and public health should work together to develop joint strategic agendas.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

Both entities should be working toward common goals for human services, specifically around vulnerable populations such as children in foster care.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

The ACC should be addressing issues of underinsurance, specifically high deductible plans and the gaps in care they sometimes create. Insurers in the insurance marketplace need to be fully educated on the services generally required to treat patients with mental health and/or behavioral health needs. Historically, the standard insurance policy includes inpatient benefits. With parity in place, an entire continuum of services should be offered to ensure the best quality outcomes.

The models developed in the ACC Program should be extended to the exchange marketplace and the broader commercial plans, aligned with the State Improvement Model (SIM).

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Regulatory agencies should be removing regulatory barriers to the delivery of high quality, efficient care. The Division of Insurance needs to assume a more active role in the review of insurance claims and payment practices and the related requirements of compliance.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

The RCCOs should be required to have a defined stakeholder engagement process in place that includes clients, families and client advocates. That process needs to be a part of their strategic planning process.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

RCCOs should support and leverage existing relationships between PCMPs (including community mental health centers) and stakeholders, community organizations, social services and public health agencies, government, non-profits, etc. MHP has an extensive array of partnerships in our community and is co-located with many of these partners. Advisory groups and shared decision-making might be helpful.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

See #40.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

The opinions and concerns of the various stakeholders, including clients and families, should be united in a strategic or operational planning process.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

No

a. If no, what are the gaps?

Gaps exist across the board (dental care, hospital beds, psychiatry).

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

There is a gap in service for folks on the autism spectrum and for traumatic brain injury. Some gaps reflect resource shortages or the limitations of treatment knowledge.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

Hospitals should act as a provider of services for inpatient needs.

b. What role should pharmacies play in the next iteration of the ACC Program?

Pharmacies are not as engaged as they could or need to be. They also need incentive alignment.

c. What role should specialists play in the next iteration of the ACC Program?

It depends on who is defined as a specialist. In some cases, specialists may be the most appropriate healthcare home (PCMP).

d. What role should home health play in the next iteration of the ACC Program?

Home health definitely needs to play a role. As an ancillary provider, home health needs a value assigned for the services they provide to the home-bound population.

e. What role should hospice care play in the next iteration of the ACC Program?

Hospices are another ancillary provider that need a value assigned for the services they provide to patients in hospice care.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

Both organizations serve populations with complex health needs. They should be supported in working with RCCOs around the array of services they need. Folks waiting for services from Community Centered Boards often experience delays, which is an issue. What role should counties play in the next iteration of the ACC Program?

Counties need to be engaged in the ACC. Local involvement is required for the ACC Program to be successful. A county's role will vary from county to county.

g. What role should local public health agencies play in the next iteration of the ACC Program?

Population health goals should be aligned between Public Health and the ACC.

h. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

Nonprofits like the FQHCs and the community mental health centers should be full healthcare provider partners in the process. Safety net providers such as CMHCs and FQHCs have long-standing experience in integrating care, attending to the social determinants of health, and managing complex healthcare needs. These skills could be better leveraged.

45) How can RCCOs help to support clients and families in making and keeping appointments?

These activities are best carried out at the local and provider level. RCCOs can ensure that adequate resources are available to support these activities, including transportation support.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

The RFP should hold bidders accountable for outcomes and provide the flexibility for local solutions. I the case of Community Health Workers and Patient Navigators, service codes would need to align to their scope of work.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	X
On staff (salary) at	☐

RCCO	
Per Member Per Month Payment	?

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

Oral health is as important in integrated care settings as physical and behavioral health. The RCCO should absolutely be incorporating the coordination of dental care and enlisting a network of providers. Dentists need incentives to encourage their participation.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

Cultural competence is the ability of a provider to recognize and deliver care that is consistent with the cultural beliefs and practices of the individual receiving care. The provider must have the ability to adapt medical practices and the delivery of healthcare services to ensure that those experiences are congruent with the cultural beliefs of the individual receiving care, including family members.

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

Providers need to include bilingual bicultural community members to help build health literacy in that community, for example the Promotoras program.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

It would be helpful for the RCCOs to target specific populations and establish outcomes related to engaging those populations, thereby creating an incentive for providers to more effectively conduct outreach in those communities.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

If a preferred network is helpful in managing risk and securing care, they should be allowed. Networks should be developed around variables such as quality and value.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

The ACC needs to connect people with health homes and work to understand and overcome what prevents this from happening, e.g. hours of operation for PCPs, transportation obstacles, etc.

The ACC needs to fully fund psychiatric evaluation services within the ER or virtually.

Furthermore, ACC needs to identify the services that can be provided outside of the ER—assuming those services are less expensive in a non-acute environment—and incentivize their delivery in appropriate settings. Medicare has followed this course for avoidable readmissions.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

NA

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

Hold them accountable for outcomes and not how they achieve those outcomes. Incentivize high-performing programs.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

Shared savings.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

We are in favor of measuring outcomes based on conditions. Disease registries can be a useful tool.

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals? T

The current payment structure minimally supports the goals of the ACC. Prometheus or other bundled or global payment systems with risk-based shared-savings across providers and RCCOs would better support goals because the approach aligns incentives.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

As a community mental health center, we currently receive capitation payments. We believe those payments should be continued under an at-risk global payment system because the approach provides the most effective means of achieving the triple aim.

Over time, all services across the continuum should be included, although the approach may need to be incremental.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Yes, behavioral health providers have the infrastructure to successfully tie payments to value.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

NA

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

The RCCOs should participate in a shared-savings distribution that creates the right kind of incentives for providers. Their role would be to analyze the data and provide objective feedback to the providers regarding impact, quality and cost of care, thereby developing the methodology for the distribution of funds.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

The ACC should consider an incremental implementation of the Prometheus System for payment reform.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

Measures must be tied to the individual. All quality and outcome measurement needs to directly measure the individual's care experience.

1) Condition specific health outcomes (e.g., Symptom Reduction)
2) Functional health outcomes (e.g., Improved Level of Functioning and ability to participate in meaningful daily activities)
3) Patient Engagement (e.g., Patient Activation, Self-Management Skills and/or Health Self-Efficacy)

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	X	☐	
SF-12 Health Survey	X	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	X	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

Population health should be measured according to cost and utilization.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐

None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)?

There should be a balance between common and local measures. Common metrics allow overall system improvement and benchmarking across regions. The locally selected/defined measures serve as an incubator for new measures that promote system/service innovation.

Should providers and RCCOs be paid on the same KPIs?

Yes, the payment between these entities should be aligned.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Potentially, both could work. Providers already operating at a high level should not be penalized by a lack of room for improvement and therefore may be benchmarked against national or local standards. In cases showing valid reasons for lower performance, the ability to demonstrate improvement rather than having payments withheld could serve as an incentive to improve performance.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

Yes. The data must be provided and monitored on a routine basis in order to impact the quality of care and health outcomes.

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

We use the CCAR and DACODS and participate in OBH's C-STAT program. We are at the beginning stages of being reimbursed based on these measures.

There are also performance indicators based on our participation as a provider in the Medicaid mental health capitation program.

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	X	
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	X	☐
Health risk assessment software	☐	☐
Practice assessment tools	X	☐
Practice management tools (scheduling, billing)	X	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	X
Patient education/wellness tools	X	☐
Provider/case manager directory	X	☐
Shared decision-making tools	X	☐
Telemedicine software	☐	X
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the 5DAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	X
Care management tool	☐	☐	☐	☐	X
Care transitions alerts	☐	☐	☐	☐	X
Electronic Health Records (EHRs)	☐	☐	☐	☐	X
Practice assessment tools	☐	☐	☐	☐	X
Health risk assessment software	☐		☐	X	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	X
Client web portal for communicating care plan, services, benefit enrollment	☐		☐	☐	X
Patient education wellness tools	☐		☐	☐	X
Provider/case manager directory	☐	☐	☐	☐	X
Shared decision-making tools	☐		☐	☐	X
Telemedicine	☐	☐		☐	X
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

The primary barrier is the lack of certainty regarding the payment mechanism. Secondary barriers include upfront infrastructure and the time and expense of installation. The efficient use of HIT tools needs to be built into the actual provision of care.

81) How can Health Information Technology support Behavioral Health Integration?

HIT can support behavioral health integration by utilizing EHRs that integrate physical health and behavioral health.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

Yes, we recommend a shared resource for data and analytics. At a minimum, this shared data set would include claims data, pharmacy data, diagnostic data, lab data and social determinants data.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

Technology needs to support health information exchange.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

Potentially, yes, there should be a shared population management tool. In terms of population health analytics, a common tool that includes a comprehensive examination of the various costs that drive overall cost—behavioral health, social determinants, etc—could be useful.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

The usual demographics, contact information, credentials and, eventually, quality data.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

Make available clinical and system involvement that crosses services systems/providers. Inform providers where and with whom patients are receiving services. And lastly, support health information exchange.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

A cloud-based healthcare exchange.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

It's imperative that we have a real-time bi-directional information exchange in order to adequately manage a patient population.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 087

Accepted by: KJDW

Notes: Standard cover sheet added; revised numbering in HIT section

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: David Myers
Location: Englewood, Arapahoe, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Metro Community Provider Network
Location: Englewood, Arapahoe, CO
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): FQHC

Are you currently involved in the ACC program?

☒ Yes
☐ No

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☒ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
MCPN has been a provider with two RCCO's – Colorado Access and CCHA.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
MCPN has been a Medicaid provider for 25 years.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

Partnerships and enhanced relationships with hospitals. Patients are getting more care coordination, there's a welcomed focus on patient outcomes. Our experience is that the two RCCO's we work with perform very differently and the best examples of RCCOs working well are when they provide support and training and when they act as a catalyst for communication among different providers. Our experience with RCCO's with sophisticated infrastructure and experience is that there's a commitment to data and data driven outcomes.

Another area which has worked well is the convening of groups to discuss payment reform. Our experience has also shown us that the best RCCO's can partner with providers to do practice management improvement.

The PMPM payment is more effective in program development and implementing best practices as opposed to reimbursement for provider encounters. We would ask that the pmpm reflect the work necessary to create the desired outcomes.

2) What is not working well in the ACC Program?

- *Attribution is still not working well. We continue to see patients who want us to be their PCMP but it is difficult to get them attributed to us.*
- *Data are neither timely nor transparent. There's very little support for data interpretation or analysis on how to make it actionable. Additionally data are not granular enough to determine what the cost drivers are.*
- *Rewards (or lack thereof) are confusing and minimalized. MCPN is still not sure if and when it's earned back the $1 and in some cases it doesn't really relate to MCPN's performance – rather to the performance of all the providers in the region.*
- *Related to the above is a failure to appropriately recognize/reward leaders in cost/quality.*
- *Being in multiple regions has created differing priorities and strategies which are not always coherent (for example we had a diabetes intervention program with one RCCO but not the other – it created a siloed program in which if you lived in one county you benefited from the services but you could not benefit from the services if you lived in another county even though you were seeing the same provider in the same clinical location).*
- *RCCO's have different abilities to manage the program. For example, MCPN had a mini-grant with each of its RCCO's. In one case the RCCO was incredibly efficient in contracting and working collaborative in creating positive outcomes and grant deliverables. In the second case, the RCCO was a barrier to getting a contract and, because of the delay, MCPN did not get its contract until well into the grant year. Rather than working collaboratively, the second RCCO tried to micromanage the grant which produced considerable frustration.*
- *There's a lack accountability of some RCCOs related to funding issues.*
- *Conflicts of interest are not disclosed nor addressed and some RCCOs proceed down a course that does not subscribe to the well being of the entire region.*
- *RCCO's differ in their ability to communicate effectively and some RCCO's have extremely poor communication commitments. For example a major initiative was discussed in one of our RCCO's that had significant impact on MCPN and its patients and there's been virtually no serious attempt to include MCPN in the conversation. All communication has been through a community partner despite*

the request of MCPN's CEO to be included in the decision-moking process. When this wos brought to the ottention of the RCCO, the response wos to leove o voice messoge directed to the MCPN CEO soying the progrom wos o wonderful ideo ond coll if there were ony questions.

- *Some RCCO's hove on ogendo thot does not olwoys seem equitoble. For exomple, under the 1281 opportunities, one RCCO ignored MCPN in developing its proposol. When osked, the RCCO soid something to the effect thot MCPN wos so sophisticoted thot it did not need 1281 help ond the focus should be on the privote sector which needed more help. This of course ruled out ony opportunity to discuss poyment reform or olternotive poyment systems.*
- *The exponsion populotion wos included in the KPI's even though there wos not boseline doto to evoluote.*
- *It is not olwoys cleor where the dollors go ot the RCCO level; we would like to request more tronsporency in this oreo.*
- *Heolth Colorodo should provide feedbock/confirmotion to PCMP's on potient's enrollment stotus ond reottribution.*
- *A comprehensive stote wide gop onolysis needs to be conducted on speciolty core occess.*
- *Mony FQHC CICP potients who ore enrolled into the ACC ore put into the unottributed bucket due to o lock of cloims doto. We would like to recommend thot FQHC's be given on opportunity to provide visit doto for CICP potients to be correctly ottributed.*

3) What is working best in the Behavioral Health Organization (BHO) system right now?

The finoncing mechonism is o model thot MCPN strives to emulote in thot it's efficient ond rewords performonce. The BHO structure olso mokes conversotions eosier ot o regionol level.

We olso find the BHO's ore working more colloborotively with FQHC's. Another mojor development is the lounch of the Crisis response system.

4) What is not working well in the BHO system?

- *CCAR requirements (need I soy more?)*
- *There seems to be o focus on gronting credit for certoin covered diognosis ond procedures but not others in the primory core setting. We're often told thot services in our system ore not countoble in the BHO world.*
- *Reloted to the obove, the current system is too limited on whot con be diognosed ond treoted ond tends to exclude potient populotions with orgonic ond troumotic broin disorders*
- *The system segments Medicoid from non-Medicoid ond creotes o differentiol between those two populotions.*
- *Lock of psychiotric core for high need potients. Psychiotric conditions ore o lorge ER driver*
- *Different levels of understonding of integrotion ocross the RCCO's*

5) What is working well with RCCO and BHO collaboration right now?

Eosier more streomlined communicotion in RCCO's who ore controcted to serve os the BHO.

6) What is not working well with RCCO and BHO collaboration right now?

- *The most significont borrier is doto does not flaw well between the BHO's ond the praviders in the RCCO.*
- *The facus on PCMP in the RCCO world morginalizes the BHO's ond their work. Same of my portners soy "it's hard ta hove a ploce ot the table" when the price for playing is thot you're a PCMP.*

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

The next step should be the development of o plon to integrote systems of care, system sovings ond potient core. For exomple, there should be discussion on specific BH KPI's, and on incentives for fully integroted practices

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	Siloed funding
Community Behavioral Health Services Rule	☒	☐	Creates different expectations and deliverables, CCAR is burdensome
Covered diagnoses list	☒	☐	Too limited (see above)
Different behavioral / physical health reimbursement	☒	☐	Creates siloed funding
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☒	☐	Given lack of programmatic integration, fee structure creates contentious issue
Per-member per-month amount	☒	☐	Yes, payment is not reflective of the work required especially for the FBMME population
Physical space constraints	☒	☐	
Privacy Laws (HIPAA, 42 CFR)	☒	☐	It's a barrier to flow of information, especially on IT highway
Professional / cultural divisions	☒	☐	10 min office visits versus 50 min office visits
RCCO or BHO contracts	☒	☐	Excessive lead time for contract approval by state
Staff capacity	☒	☐	Not enough candidates to hire. There are significant "pipeline issues".
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☒	☐	42 CFR is a barrier. Diversity of IT systems is a barrier.
Training	☐	☐	

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Others	Please type your response here.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

SIM definition of integrated care and current HCPF definition should be supported and enforced.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Currently there is no financial incentive or award for integrated care producing better outcomes. The oppasite should be true.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

A series of value producing activities which link the healthcare consumer with services that successfully drive cost, quality, and customer service.

NCQA: The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.

NCQA 2014 PCMH Standards: Four elements: Assuming accountability for care coordination, providing patient support, developing relationships and agreements with key outside providers, and establishing connectivity that assures appropriate information transfer.

MCPN care coordination provides assessments, interventions, coaching, and support to MCPN patients <u>proactively</u> by assisting in managing the patient's healthcare needs.

How should RCCOs prioritize who receives care coordination first?

RCCOs should not be prioritizing who received care coordination first, is should be the PCMP.

All PCMP's should standardize risk stratification processes with a focus on high need populations; which includes people with co-morbid conditions/poorly controlled conditions who are at risk for emergency room use and potential admission. Prioritization factors should include: Utilization patterns, cost, social determinants of health, behavioral health needs, number of conditions and medications, and patient's weighted CRG score.

b. How should RCCOs identify clients and families who need care coordination?

PCMP should be identifying clients and families and notifying RCCOs

c. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

They should develop highly sophisticated information highways to receive care coordination data from PCMP, RCCOs should not impose external tools for data collection on PCMP. <u>Standardize</u> monthly metrics across the RCCO's. Continue yearly audits for best practice information gathering and coaching for improvement opportunities.

12) What services should be coordinated and are there services that should not be a part of care coordination?

All services should be care coordinated but managed at the PCMP level. PCMPs should not be administratively burdened to such a degree during care coordination.

Hospitals need to take accountability for care coordination during a patient's hospital stay and provide a warm hand off to the patient's PCMP upon discharge.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

Various stratification tools exist that can guide levels of care coordination. One drawback, however, is that many of these measures and scales do not take into consideration a patient's support system.

Some specific examples of what's needed to help care coordination is knowledge of benefits, med records, real time hospital records, DOC records, specialist and lab reports, and pharmacy information. The patient also needs a comprehensive health need assessment that includes complete information regarding patient's care coordination needs.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

As a general statement, funding and business priorities often define a provider/institution's care coordination model. Because there is not integrated funding there is no incentive to provide integrated care coordination. For example, there is poor to no coordination at all between long term Medicaid benefits and short term Medicaid benefits. In considering total cost of care, the acute care program is totally separate from long term services.

a. What care coordination is going on today?

MCPN's approach is to provide holistic patient-centered care that is well managed and coordinated. Clinical care coordinators are the hub of the wheel in an MCPN patient's care. They ensure that all aspects of a patient's life are being examined in order to improve health outcomes.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

Many of the hospitals in the Denver metro area have different standards and definitions of care coordination which in turn affects patient's care transition process from hospital to medical home.

Additionally, care coordination offered through the DOC tends to be done in isolation which affects patient's transition upon release.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

CTP (Community Touch Point) reporting from ALL RCCO's. This report allows care coordinators to see what care coordination services a patient may be receiving somewhere in the community and who should take the primary care management role.

d. What are the gaps in care coordination across the continuum of care?

Frogmented hospitol core tronsitions due to limited hospitol stoff to ossist in providing odequote dischorge educotion ond support. Deloy in hospitol records. Access to speciolty core. Unrelioble Medicoid- provided tronsportotion.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families: *Pleose see our comment under "other".*

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☒	
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	
Daycare / childcare	☐	☒	☒	
Economic stability & employment	☒	☐	☒	
Education	☒	☐	☒	
Environment	☒	☐	☒	
Food access / nutrition	☒	☐	☒	
Health literacy	☒	☐	☒	
Housing	☒	☐	☒	
Language or translation services	☒	☐	☒	
Literacy	☒	☐	☐	

Transportation	☒	☐	☒	*THE NEMT contract needs to examined as it is not currently providing timely services to patients.*
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved. *The RCCO's should be more involved in building relationships with organizations/services that are community based so that all PCMP's can have a complete and updated resource list.* *A care coordination model should address these issues; however, the PCMP should be the site of care coordination. To the extent that the RCCOs are providing care coordination, yes they should address these issues*			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	*See answer below under "other".*
Certified Addiction Councilors	☒	☐	
Certified Nurse Midwives	☒	☐	
Community Health Workers	☒	☐	
Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☒	☐	
Licensed Mental Health Counselors	☒	☐	
Licensed Professional Counselor	☒	☐	
Masters of Public Health	☒	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	

Nurse Practitioners	☒	☐	
Patient Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☒	☐	
Psychiatrists	☒	☐	
Psychologists	☒	☐	
Registered Nurses	☒	☐	
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	
Other	Please type your response here. *Each one of these has a potential role in a care coordinated delivery system. Depends on configuration of health system, composition of care teams, and community demographics*		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient: *See response under "other".*

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☒	
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☒	☐	
Children involved in the foster care system	☒	☐	
Children with a chronic illness	☒	☐	
Children with a serious emotional disturbance	☒	☐	
Children with medical complexity	☒	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	
Transition-age adolescents	☒	☐	
Parents and families	☐	☒	
Pregnant women	☐	☒	
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☒	☐	
Adults with a chronic illness	☒	☐	

Adults with a behavioral health diagnosis or substance use disorder	☒	☐	
Clients involved in the criminal justice system	☒	☐	
Clients with a disability	☒	☐	
Clients in a nursing facility	☒	☐	
Elderly clients	☐	☒	
Frail elderly clients	☒	☐	
Clients in palliative care	☒	☐	
Other papulatians, please comment: *Core coordination should be individualized; it's caunterintuitive ta develop specific, papulotion madels.* *Potients who are deemed "high risk" require more comprehensive core coordination which can be resaurce heovy and time consuming. Low risk potients may benefit fram minimol/moderote care coordinotion, or moy require no care coordinatian interoction at all. This must be tailored to eoch potient's specific needs.*			

18) How do yau envision the RCCOs working with child-serving agencies in the state ta deliver care for medically ar socially complex children ar for children involved in the faster care system?

RCCOs shauld assure that the child has a PCMP. Child serving agencies should be working closely with the RCCO's as well as with the patient's PCMP to ensure the patient's needs are being properly communicated and addressed.

19) How shauld care coardination be evaluated? How should its outcomes be measured?

Impraved clinicol outcomes, cost reduction, improved quality of life. Core coordination measures should be standardized acrass the RCCO's with delegated practice's input. NQF measures should be considered as well as evidence based taals such as the PAM/CAM.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) ta cover care coordinatian and ather expenses, like developing and supporting a netwark af providers.

MCPN daes nat have the resaurces to calculate a pmpm. As a generol rule, the pmpm should be of saund actuarial basis and based an the work needed to produce the desired outcomes.

Furthermore, the cast varies as it is based an total attributed patients and level of staffing. Additianally, different models of care coordinotion vary in cost/resaurces depending an the size of a practice and a practice/orgonizotion's cammitment ta providing high quality core coordinotion.

a. What is the PMPM cost far praviding care coordination services?

Please see above.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by populatian?

Yes, patients that are deemed as high risk are more time and resource intensive and should have a higher pmpm. Incentives should be awarded to PCMP's who are able to lower costs and improve outcomes for particularly complex high need patients.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

Yes there should be a ratio established on evidence and research. There should also be adequate funding to assure adequacy in care coordinator to client ratio. MCPN works off of a 4 tier care coordination risk stratification model that warrants smaller caseloads for patients who are tiered high and needing more intensive services. Patient's needing intensive care coordination fit into a 1 to 30 care coordinator to client caseload. Patients with mid-moderate needs have proven to have positive outcomes in a 1 to 100/150 care coordinator to client ratio. Additionally, care coordination should be broken out into pediatric care coordination and adult care coordination based on the varying needs and resources.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50 (intensive)	☒
51-100	☐
101-200 (mid/moderate)	☒
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

Core coordination outcomes should be evaluated consistently across the RCCO's with standardized measures from NQF and NCQA. Best practices should be shared across the RCCO's in developing annual audit reviews of PCMP's. The outcomes should be improved clinical outcomes, cost reduction, and improved quality of life

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

As o closing comment, MCPN would like to reiterate thot reseorch supports the idea that core coordination ot the PCMP level is the most effective. Thot principle should be the guiding wisdom in building o state sponsared core coordinotion effort.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

There should be standardization in data, in payment methodology, in communication, and in recognizing FQHCs as a unique type of provider in RCCO structure. MCPN is cautious about mandating more than is necessary since our experience has been that the State requirements are pushed down to the PCMP's sometimes without regard to the PCMP's system of care.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

- *A bidder should devote a portion of the budget to assessing community needs and strengths. It should also develop financial transparency with the community so that it is apparent that financial resources are being spent in the community for the purposes of improving health status. This includes keeping the medical loss ratio at 90%.*
- *Parallel to that, there should be a clearly defined financial commitment to building the community relationships in the form of mini-grants. PCMP's, such as FQ's. which can truly impact outcomes should be given representation in governance and in decision making.*
- *Conflicts of interest should be stated and addressed as part of the bidding process. There should be clear and measurable deliverables in the community engagement plan.*
- *Finally, there should be letters of support from FQs, hospitals, health departments and other safety net providers*

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

- *It is true that a PCMP operating in multiple RCCO's encounter additional administrative challenges. Working with one RCCO will create administrative efficiency especially under payment reform. MCPN cannot emphasize more strongly its desire to work with one single payment system vs. multiple payment systems under multiple payors.*
- *Of paramount importance, if this provision is implemented, is in assuring and holding RCCOs accountable that they will assign unattributed patients equitably even if a provider is solely contracting with a different RCCO. This goes back to the previous statement on having RCCO's declare conflicts of interest and inviting scrutiny on how Medicaid clients are assigned to a PCMP.*

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes, the maps should reflect natural referral patterns. Suburban Denver should not be split into two RCCOs

28) Should the BHO region maps change? Why or why not? If so, how?
MCPN has no opinion on this.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

MCPN doesn't feel it hos enough knowledge to onswer this question. Whot we do know is that there should be no disruption to payments or core processes in any tronsition periad.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

- *Improved systems for patient's ability to select RCCO*
- *Allow 12 month continuous eligibility,*
- *Provide for olternate FQ payment mechanisms,*
- *Limit medical loss rotio to 90%*
- *After patient choice, those not making a PCMP selection should be auto attributed to a narrow group of providers that meet certain requirements with regard to both occreditotion (JCAHO or AAAHC) ond those practices which ore committed to the principles of PCMH. If the goal is to improve outcomes, it makes no sense to assign potients to practices which have no systems or commitments to practice transformotion.*

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

- *The cap on dentol is a limitotion.*
- *Cose management payment should reflect both the work and the outcomes.*
- *Goinsharing should be bosed on work of the provider not necessarily by RCCO region.*

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

No, this would creote confusion and inefficiencies. MCPN sees it as both costly and o detriment to patient core.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

N/A

34) What role should RCCOs play in attributing clients to their respective PCMPs?

- *Certain RCCOs hove high degrees of conflict of interest ond should play no role.*
- *Attribution should be timely: after 3 months without attribution RCCOs should stop receiving PMPM entirely until the individual is attributed.*

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

CDPHE does public health reporting ond surveillance; RCCO's hove on intervention role. This seems to be o noturol alliance in oreos of planning and strategic development.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

No opinion

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

No opinion

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

No opinion

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

RCCO's should hove consumer seots on Governonce.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

Providers who see a significant number of the RCCOs patients should hove a role in governonce.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

There should be on expectotion within the RFP ond o plan to engoge non-RCCO providers who con cantribute to success, i.e. hospitals, etc.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Cantinue and suppart the work of PIAC.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

No

a. If no, what are the gaps?

Not enough dentists ond speciolists to serve the populotion. Administrotive ond procedurol issues don't incent them to see this populotion.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

Again, nat enough dentists ond speciolists ta serve the papulation regardless of how you slice it. Administrotive ond pracedurol issues don't incent them ta see this populotian.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

Successful outcomes depend on getting the client what they need when they need it. All of the entities listed play a role in successful care coordination.

Incentives should align with outcomes that spell success for the program with a special focus on hospital relationships.

a. What role should hospitals play in the next iteration of the ACC Program?

Poyment reform should include hospitols.

b. What role should pharmacies play in the next iteration of the ACC Program?

Phormoceuticols should be included in poyment reform,

c. What role should specialists play in the next iteration of the ACC Program?

Speciolty core should be included in poyment reform.

d. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

SEPS ond CCB's should hove o supportive role.

e. What role should counties play in the next iteration of the ACC Program?

Counties should hove o supportive role.

f. What role should local public health agencies play in the next iteration of the ACC Program?

Locol public heolth ogencies should be supportive ond o source of doto.

g. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

Agoin, these ogencies should be supportive. They moy hove on importont role in mini-gronts ond other initiotives designed to improve outcomes.

45) How can RCCOs help to support clients and families in making and keeping appointments?

These services ore best orgonized ond monoged ot the PCMP level.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

No. This is too prescriptive ond misses the point. The point is thot the rebid should reword those providers who engoge in proctice tronsformotion ond encouroge the development of PCMH's. If those providers ore recognized, they will develop the evidence-bosed systems to oddress core monogement needs.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☒
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

The role is on educotion one. PCMPs offering dentol services olso should get on enhonced reimbursement.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

RCCOs should give priority to PCMPs who o demonstroted trock record of serving underserved ond morginolized populotions.

a. What does cultural competence mean to you?

Meeting the potient's needs in o context thot tokes into occount their environment ond belief systems.

b. What RCCO requirements would ensure cultural competency?

Assuring consumer surveys include consumers of different cultures. Expressing KPI's by culturol definitions might olso identify oreos of speciol focus.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

Patience and special training are the essential elements. Appropriate tools must also be available to facilitate communication. At a minimum there should be translation services available and accommodations for interpreters when appropriate.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Part of the answer is found above under c. Additionally, reducing inequities requires special focus and interventions that are clearly defined.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

Without a capitated system preferred networks are impassible. It is our preference that payment reform moves toward capitation and then preferred networks would make sense.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Enhanced payments to PCMPS would provide walk in access outside of traditional business hours.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support: *See answers under "Others"*

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☐	☒	☐	☐
Assistance with practice redesign	☐	☒	☐	☐
Assistance with efficiency-enhancing activities	☐	☒	☐	☐
Provide web-based resources and directories	☐	☒	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☒	☐	☐
Provide clinical screening tools	☐	☒	☐	☐
Provide health and functioning questionnaires	☐	☒	☐	☐
Provide chronic care templates	☐	☒	☐	☐
Provide registries	☐	☒	☐	☐
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☐	☒	☐	☐
Offer educational materials about specific conditions	☐	☒	☐	☐
Supply behavioral health surveys	☐	☒	☐	☐
Supply other self-screening tools	☐	☒	☐	☐
Administer behavioral health surveys	☐	☒	☐	☐
Administer other self-screening tools	☐	☒	☐	☐
Prepare client action plans	☐	☒	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☒	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☒	☐	☐
Provide referral and transitions of care checklists	☐	☒	☐	☐
Provide visit agendas or templates	☐	☒	☐	☐
Provide standing pharmacy order templates	☐	☒	☐	☐
Provide comprehensive directory of community resources	☐	☒	☐	☐
Provide directory of other resources	☐	☒	☐	☐
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others	*For sophisticated practices there should be support to conduct most of these activities at the PCMP level. The caution, as always, is the tendency for RCCO's to mandate how a practice delivers care. The other caution is the "pushing down the work" phenomenon when a RCCO has a*			

contract deliverable and delegates the work to the PCMP without regard to the PCMP's workflow and processes. A better solution might be fore the Department to contract with a non-RCCO entity such as Health TeamWorks to develop many of these items.

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

RCCOS should be supportive, but not restrictive, ond develop o structure to oword gronts for innovotive proctice tronsformotion proposols.. RCCOs should fovor PCMPs thot hove undergone proctice tronsformotions.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

Have standards that are based in NCQA recagnitian as well as capitatian payment mechanisms. JCAHO and AAAHC are alsa entities which accredit PCMH's. Recagnitian shauld alsa be based an praven clinical cast effectiveness and patient-centered efficiencies and clinical autcames.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

RCCOs shouldn't contract with PCMPs who are nat capable of utilizing diseose registries.

58) Please share any other advice or suggestions about provider support in the ACC.

High performing PCMPs should be reworded far individual performance not performonce of the region.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

No, the methodology is so diluted thot there is no correlotion between performonce ond incentive we receive. A PCMP should be poid for whot it does.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

HCPF should work with CHCs to develop ond pilot on APM thot moves owoy from FFS ond towords populotion-bosed poyment with o poth to toking on risk over time for interested CHCs. The APM should serve os o bose.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

MCPN does hove the infrostructure ond should be oworded occordingly.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

We do not plon on bidding.

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

RCCOs moy hove o role os TPA but not os the poyor.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

Negotiotions need to be directly with PCMP with the RCCOs os o portner. The RCCO's should not be ollowed to negotiote without the PCMP ot the toble. MCPN leorned of ot leost one situotion in which the RCCO was negotioting with HCPF on pmpm for primory core ond MCPN wos not included in those discussions. Agoin, the conflicts of interest con be enormous with some RCCO's in who they decide to reword ond support ond in who they choose not to support.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

Key Performonce Indicotors ore o good tool but should be focused ond the doto methodology should be re-worked to ossess longitudinol effects, not just quorterly phenomenon.

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	*Gold stondard, most opprapriote to meosure potient experience*
SF-12 Health Survey	☐	☒	
Other types of client interviews / surveys	☐	☒	
Patient Activation Measure	☐	☒	
Focus groups	☐	☒	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how shauld populatian health be measured?

Laok beyond HCPF, portner with CDPHE to develop survey tools. The Deportment should support CHC efforts to develop stotewide a clinicol doto tool

68) How shauld quality and perfarmance data be reported to the RCCOs, PCMPs, and the public?

Increose tronsparency af how data is utilized. Work with PCMPs to develop the model which will be actionable and useful. Currently the dota is presented withaut ony reosonable woy to understond the methodalogy and it is so ald as ta nat be actionoble..

69) **Measures for payment.** Please use the table below to describe haw many measures should be tied to payment at ane time. These could functian similarly to Key Performance Indicatars, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐

None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☒
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

MCPN would like to see a formula which is incrementally rewarding as opposed to a fixed formula. Initially the formula should start out low and accelerate payment to high performers.

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Yes, and Yes

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

The question is to how to reward high performers yet incentivize low performers. The system should have both elements – one to reward based on national benchmarks and one to encourage low performers to improve their outcomes.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

Yes

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

Administrotive costs should not exceed 10%

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

UDS, MU, Medicore Advontage, ond PCMH metrics.

Yes, we are being reimbursed for some of these meosures

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other: *N/A*		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☐	☒
Care transitions alerts	☐	☒
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☐	☒
Practice assessment tools	☒	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☒	☐
Shared decision-making tools	☒	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-S, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☐	☐	☒
Health risk assessment software	☐	☐	☐	☐	☒
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☒
Patient education wellness tools	☐	☐	☐	☐	☒
Provider/case manager directory	☐	☐	☐	☐	☒
Shared decision-making tools	☐	☐	☐	☐	☒
Telemedicine	☐	☐	☐	☐	☒
Other: *Eoch of these elements con be very useful in the right setting with the right potient.*	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Access to occurote ond timely informotian. An odditionol borrier is cost. A third borrier is a shortoge of competent IT stoff. Additionolly there is the lock of interoperability between systems as a borrier. As an important example, core coordinotion softwore tools ore not interoperoble with EHRs. Finally is the inobility to bill for HIT related services

81) How can Health Information Technology support Behavioral Health Integration?

By creoting o unified potient record. The borriers to this are cost, 42 CFR, ond different technologies.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

Yes, there should be a shared resource for dato and onolytics. The bosic criterio should include: Heolth risk assessment criteria that is linked on the data highwoy to EHR's ond other providers, KPI doto with less log time thot includes potient's hospitolizotion locotion and reporting chief complaint (in TREO this doto currently has to be trocked potient by potient in the potient profile), weighted CRG ond bose risk group, ond specific quality meosures infarmotion: both clinicol ond bosed on o defined RCCO core coordinotion metrics.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

Yes, with on emphosis on toking o PCMP's workflow ond helping to lood it an the dato highwoy so it becomes port of the CCD. The bosic criterio should be bosed on predictive voluing by segmenting potients bosed an the KPI's. It should ollow visibility into doto for patient's entire heolth neighborhood to view, in order to allow doto streoms from onyone providing core coordination for the potient. This should oll hoppen in reol time. The tool should pull in ossessment informotion such as the SCP, HRA, hospital ADT, PCMP proctice doto, ond quolity meosures from PCMP's EMR. The tool should outomote tosks bosed on patient's risk volue and adjoining protocols in order to divide out core teom responsibilities. It should olso hove doto preservotion copobilities as well as the ability to pull full doto sets doily. Lostly, the workflow should auto-ossign coseloods based on new attribution lists and account for the odd/delete churn thot PCMP's must deol with month to month. Ideolly, the core monogement tool can serve as a community tool to torget more impactful (ond doto driven) interventions with ACC patients.

As olwoys, the coution is thot this should be done with the input of the PCMH's and not become another "controct deliveroble" imposed by the RCCO's.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

Yes. The bosic criterio should be the obility for o PCMP to run reports for potient educotion, teom ond provider improvement. Also there should be o mechonism to view ond strotify doto bosed on oll BH, Orol heolth, preventive core, ond ocute ond chronic conditions. This tool should olso hove the obility to torget <u>rising risk</u> populotions into cotegories for core coordinotion outreoch.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

Needs to be up to dote ond cleor who is occepting new Medicoid ond timeliness of occess.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

Need to be more reol time ond octionable. RCCO needs to partner with PCMPs to loy groundwork to create plotform which oll proviclers share doto.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

The Deportment needs to suppart CORHIO in completing the informatian highwoy.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

It should not be in the RCCO scope of service to osk them to create ossistonce and resources for HIT infrostructure. This is o huge respansibility ond should be left to those orgonizations which hove this functian as their primary purpose. Assigning RCCO's that responsibility would dilute their focus ond impoct

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

CORHIO's role is vitol ond the single most importont element that MCPN needs to succeed in core monagement

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

SDAC doto should be more gronulor especially in the areo of providing cost drivers for individual potients. Agoin we can't emphosize strongly enough the need to hove octionoble doto.

Colorado Department of
Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 088

Accepted by: KJDW

Notes: Standard cover sheet added; formatting standardized

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Wendy Nading, RN, ND
Location: Englewood, Arapahoe, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Tri County Health Department
Location: Adams, Arapahoe, Douglas
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Public Health Agency

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☒ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Community partner as the local public health agency with interactions limited to meetings and workgroups

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Direct service provider to Medicaid clients for family planning, immunizations, family nurse partnership; care coordination to Medicaid clients for Health Care Program for Children with Special Needs; Medicaid Presumptive Eligibility site; Healthy Communities site

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☒ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now? **Supporting primary care with medical home transformation**

2) What is not working well in the ACC Program? **Clear delineation and communication within the community of service delivery including what specific services are offered and who receives these services, both provider and client. Engagement of key stakeholders; collaboration at the community level with service providers to understand and map out what each organization is already doing and how partnering with the RCCO can enhance and not duplicate services; sharing data to enhance services and efficiencies**

3) What is working best in the Behavioral Health Organization (BHO) system right now? **Stakeholder feedback in the TCHD jurisdiction from a convening perspective indicates a positive working relationship between the BHO and mental health providers; concern that new system may be more disruptive than helpful if new processes will be required**

4) What is not working well in the BHO system? **Payment when both physical and mental health services are provided; sharing data**

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1] **Programs focusing on prevention**

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services. Using the table below, please explain which issues are barriers, and how they can be addressed:**

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

b. How should RCCOs prioritize who receives care coordination first? **Map and assess what care coordination is already occurring, by service provider and scope; identify gaps through collaboration with other care coordination providers; based on gaps, either provide within the RCCO if the necessary skill set is present or refer if this expertise is already being offered by a partnering provider**

c. How should RCCOs identify clients and families who need care coordination? **Develop an advisory committee/board at defined community levels (for example by county, zip codes or hospital districts) within the RCCO that includes comprehensive stakeholder involvement (providers, CBOs, local public health, CDPHE, HCPF, local schools) to collectively determine the mapping, assessment, and prioritization of care coordination; the RCCO can function as a 'coordinator of care coordination' across multiple systems and providers with a focus on streamlining the referral process but not providing direct care coordination unless a gap is identified; consider the RCCO funding existing care coordination programs instead of building expertise inside the RCCO when it is already established in the community**

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider? **Shared care coordination web based application (similar to the CDPHE e-CaST care coordination application); allow PHI exchange across care coordination systems and providers**

12) What services should be coordinated and are there services that should not be a part of care coordination? **See 11 b and c for response**

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs? **If an advisory board is in place, this type of information could be collectively determined by multiple stakeholders based on community characteristics. Care coordination is so broadly defined that this questions is difficult to answer.**

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today? **Primary and specialty care, behavioral health providers, hospitals, CBOs, human services, local public health, schools.**

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different? **Each community responds with different resources but extensive care coordination is occurring by multiple service providers. There is minimal detailed understanding of these activities across systems.**

c. How can the ACC avoid duplicating or disrupting current care coordination relationships? **Systems work on bringing care coordination providers together to map services across populations and develop a roadmap to guide service delivery across the continuum of care.**

d. What are the gaps in care coordination across the continuum of care? **Gaps still need to be identified based on a comprehensive assessment of current services and capacity.**

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	Should the RCCO have a role? No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☒	☐	As a clearinghouse and referral source for clients to established community providers; provider education on the community resources available
Affordability (assistance with prescriptions or co-pays)	☒	☐	☐	
Daycare / childcare	☐	☒	☐	As a clearinghouse and referral source for clients to established community providers; provider education on the community resources available
Economic stability & employment	☐	☒	☐	As a clearinghouse and referral source for clients to established community providers; provider education on the community resources available
Education	☐	☒	☐	As a clearinghouse and referral source for clients to established community providers; provider education on the community resources available
Environment	☐	☒	☐	As a clearinghouse and referral source for clients to established community providers; provider education on the community resources available
Food access / nutrition	☐	☒	☐	As a clearinghouse and referral source for clients to established community providers; provider education on the community resources available
Health literacy	☒	☐	☐	

Housing	☐	☒	☐	As a clearinghouse and referral source for clients to established community providers; provider education on the community resources available
Language or translation services	☒	☐	☐	
Literacy	☐	☒	☐	As a clearinghouse and referral source for clients to established community providers; provider education on the community resources available
Transportation	☒	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination**. Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	**Coordinate care?** Yes	No	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☒	☐	Clinical care coordination
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☒	☐	Non medical coordination outside the health care delivery system; community based; refer to literature to ensure evidenced-based design
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☒	☐	Behavioral health linkages, patient assistance with specialized community supports such as disability and housing
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	

Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☒	☐	Non medical coordination within the health care delivery system as part of a care team
Peer Advocates	☐	☐	
Promotoras	☒	☐	Non medical coordination outside the health care delivery system; community based; refer to literature to ensure evidenced-based design
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☒	☐	Clinical care coordination; lead in a multidisciplinary care team
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations**. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☐	Prevention focused; refer to CDC community guide for evidenced based strategies; HealthTeamWorks prevention guidelines; may not require individual care coordination but practice supports
Children	☒	☐	Prevention focused; refer to CDC community guide for evidenced based strategies; HealthTeamWorks prevention guidelines; may not require individual care coordination but practice supports
Children who are healthy, but in socially-complex environments	☒	☐	Prevention focused; refer to CDC community guide for evidenced based

			strategies; HealthTeamWorks prevention guidelines; ensure access to a multidisciplinary care team
Children involved in the foster care system	☒	☐	Through formal partnership with county and CDHS
Children with a chronic illness	☒	☐	
Children with a serious emotional disturbance	☒	☐	
Children with medical complexity	☒	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	
Transition-age adolescents	☒	☐	Prevention focused; may not require individual care coordination but practice supports
Parents and families	☒	☐	Prevention focused; may not require individual care coordination but practice supports
Pregnant women	☒	☐	
Adults	☒	☐	Prevention focused; may not require individual care coordination but practice supports
Adults who are healthy, but in socially-complex situations	☒	☐	
Adults with a chronic illness	☒	☐	may not require individual care coordination but practice supports to ensure disease management tools in place
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	
Clients involved in the criminal justice system	☒	☐	
Clients with a disability	☒	☐	
Clients in a nursing facility	☒	☐	
Elderly clients	☒	☐	
Frail elderly clients	☒	☐	
Clients in palliative care	☒	☐	
Other populations, please comment: **General comment about the above section: If care coordination occurs, it should be targeted in response and therefore specific. In addition, not every member of the populations listed above would require care coordination. Conversely, a client within any of the above populations may require care coordination at some point in the care continuum. If care coordination is provided from a community based multidisciplinary care team, a tailored and specific response is much more likely.**			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system? **Stakeholder engagement at the community level is critical in identifying supports already in place, capacity and gaps.**

19) How should care coordination be evaluated? How should its outcomes be measured? **Most agencies providing care coordination collect data on measuring success in addition to the data available from local public health agencies, hospitals, all payer claims database, RCCOs, etc. Layering this data together using key indicators to develop a type of needs index could be a direction of focus for the RCCO.**

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

   a. What is the PMPM cost for providing care coordination services?

   b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

   a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important? **A metric to measure RCCO engagement with community providers to clearly map out existing care coordination and delineation of scope.**

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies). **All of the examples listed plus stakeholder engagement.**

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs? **Requirements to include, by listing, of specific community representation and the infrastructure that will be used to ensure participation; attention to how to define community should be clear and reasonable; for example, if one RCCO has multiple counties, this community engagement should be ensured for multiple communities; for example, where local health alliances are active and well represented, could this be the infrastructure used to engage the community, not simply attending meetings but by carrying out coordinated and integrated activities.**

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective? **Data sharing improvements.**

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment? **Formal collaborative agreements to ensure coordinated and integrated activities.**

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services? **Formal collaborative agreements to ensure coordinated and integrated activities.**

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado? **Coordination to offer seamless enrollment assistance whether the client is Medicaid eligible or shopping the marketplace; currently the systems seem to operate as either Medicaid assistance OR Connect for health marketplace guides**

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates? **Requirements to address health literacy to increase understanding of what a RCCO is and why participation is a benefit to the client. Clients generally have no idea what a RCCO is or why the RCCO might be contacting them directly or how the RCCO partners with the medical home. Clients often receive multiple contacts with multiple messaging from multiple providers without an understanding of the purpose.**

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region? **Formal advisory board or similar structure at the community level with a work plan for coordinated and integrated activities.**

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC? **Capitalize on existing community collaboratives to provide the organizational structure to launch innovation.**

42) How should the Department structure stakeholder engagement for the ACC as a whole? **Establish minimum representation requirements, by scope (human services, public health, hospital, mental health, substance abuse, specialty care, CBO, etc,) utilizing already existing formalized workgroups/collaboratives (such as Aurora Health Access) whenever possible so the ACC effort is going into the community instead of drawing stakeholders into a newly created RCCO structure .**

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps? **Specialty care in general. Primary care with respect to timely access. Clients report using the ED because timely access to primary care is an issue.**

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program? **Advisory board participation at the community level to strategize solutions with larger stakeholder group. Share data, work processes, current capacity and resources available as part of this work.**

b. What role should pharmacies play in the next iteration of the ACC Program? **Pharmacists as part of the multidisciplinary care team, partnering with other care team members such as the RN to deliver medication therapy management at the PCMH level**

c. What role should specialists play in the next iteration of the ACC Program? **To partner as a true participating member of the medical neighborhood by increasing access for Medicaid clients**

d. What role should home health play in the next iteration of the ACC Program? **In part, participating in transitions in care initiatives, including a focus on ensuring minimal duplication of care coordination activities.**

e. What role should hospice care play in the next iteration of the ACC Program? **In part, system level advocacy voice on provider education for end of life decision making with patients and their families**

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program? ? **Advisory board participation at the community level to strategize solutions with larger stakeholder group. Share data, work processes, current capacity**

and resources available as part of this work. A focus on ensuring minimal duplication of care coordination activities.

g. What role should counties play in the next iteration of the ACC Program? **Advisory board participation at the community level to strategize solutions with larger stakeholder group. Share data, work processes, current capacity and resources available as part of this work.**

h. What role should local public health agencies play in the next iteration of the ACC Program? **Advisory board participation at the community level to ensure optimal collaboration in the following: prioritization of prevention activities; bridging PCMH activities with community linkages and supports; sharing and understanding population health data to prioritize activities and assess outcomes; outreach, enrollment and care coordination activities; and consideration of options for investment of RCCO savings into local public health to support community-based prevention activities that address both the individual (eg, smoking cessation) and community (eg, tobacco policies to reduce second-hand smoke exposure.**

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past? **Advisory board representation at the community level; partnering will most likely lead to identification of the importance of these organizations in providing direct services to Medicaid clients leading to opportunities for identifying duplication of services and utilizing these client contacts to align with ACC activities (linkages to care, health literacy, enrollment, care coordination).**

45) How can RCCOs help to support clients and families in making and keeping appointments? **Giving the resources to providers to perform these activities since they have the established relationships with the client**

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP? **If evidenced based models of care are utilized; not as a general requirement and not as a replacement for a licensed clinical care team member (RN, RD, pharmacists, social worker, behavioral health professional)**

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care	☐

Medical Provider Clinic	
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers? **increase capacity; increase reimbursement; provider consensus on standard of care (such as first ever visit to a dentist)**

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend? **Provide client incentives or disincentives; health literacy emphasis on provider training and supports; timely primary care access**

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☒	☐	☐	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☒	☐	☐	☐
Provide registries	☒	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☒	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☒	☐	☐	☐
Provide standing pharmacy order templates	☒	☐	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☐
Provide directory of other resources	☒	☐	☐	☐
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes? **Increased reimbursement**

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals? **Increased PCMH reimbursement**

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured? **Engage key stakeholders to share data to drive reporting of common indicators to determine a health index rating**

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☒	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type**. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the 5DAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☐
Care management tool	☐	☐	☐	☐	☐
Care transitions alerts	☐	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☐
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices? **Significant challenges in sharing meaningful data with partners and have barriers in place to sharing data even on a shared population**

81) How can Health Information Technology support Behavioral Health Integration?

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful. **Yes**

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful. **Yes**

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful. Yes

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of
Health Care Policy and Financing

Serial # 089

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Aubrey Hill
Location: Denver, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Coalition for the Medically Underserved
Location: Denver, CO (statewide representation)
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☒ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
CCMU has long been interested in the ACC program since we are committed to a better functioning delivery system for Medicaid patients (as part of the medically underserved population we represent).

Aubrey, our Director of Health Systems Change, has been on the PIAC for 3 years, and a co-chair for nearly two.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
We are heavily invested in Medicaid as a key coverage program for our low-income, vulnerable populations around the state.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

We will continue to participate as we have been, though we will not have financial interest in the

☐ 2-3 years
☐ 3-4 years
☒ Since before the program was implemented.

program.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

Largely, the foundation of this program is strong. The RCCOs, to our knowledge, are committed to local cultures, relationships and networks, and strengths. The RCCOs are also hard at work in ensuring PCMP network adequacy, with constant marketing and mystery shopper checks. We also see it as promising that the state is very focused on the program—constantly analyzing data and listening to partner stories—and always ready to try something new. That kind of energy is imperative for such a large challenge that we have ahead of us in trying to successfully scale up a program that was once a small pilot and is now a large program serving such diverse populations.

2) What is not working well in the ACC Program?

We were most interested in the outcomes of the CHI CAHPS survey where they discovered that there was no statistically significant difference in the care experiences between fee-for-service Medicaid patients and ACC patients. We recognize that the program's impact was still evolving at the time the survey was taken, but the results should serve as guideposts for how we move ahead and recognize the potential for positive impacts. We think that more patients could be served by care coordination that is broadly defined and well-connected to many parts of the system where patients need navigation supports. We heard from some of our focus groups that social determinants of health supports are critical, and so is a system that makes it possible for more seamless navigating to get to what they need.

Confusing paperwork and specialty referrals are the two other pieces that we know could be improved. The focus groups told us that they are not sure who to talk to or trust when they need to find out information about getting what they need out of Medicaid. We need to better understand the sources that different patient populations will turn to for advice, and ensure they have the most thorough and up-to-date information (and access to a good resource if they need it).

Specialty referrals are just a matter of strengthening the Medicaid specialty provider networks, which we know is a significant challenge, and we find it promising that HCPF is devoting some budget requests to target some gaps in care. We hope that attention will continue on this issue.

We also think that special populations within the ACC will need additional attention in how their care is managed as the ACC was not created initially with children in mind, nor those with disabilities, but now that

those populations are enrolled in the ACC, we have to be especially mindful of how we can improve the experience for them.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

As far as we know, the biggest challenge is being able to schedule two appointments in the same day and having both of those appointments covered by Medicaid, which will be tricky as we continue down the road on wholesale integration of the health care system.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

As mentioned above, we think that the first step is analyzing some of the barriers that patients face as they attempt to move through clinics that are integrated. We know we want to scale up these clinics' successes in integrating, so paying close attention to their experiences and struggles will be critical for the future.

Across all the focus groups that CCMU conducted, we heard loud and clear that patients desire integration of behavioral health and primary care. They mentioned that the more consolidated services are in general, the better. The preference is strongly for a single center where they can get all their needs met during one trip. We know that transportation is a challenge, so the more efficient we can make their visits to health centers, the better for their ability to access services. This goes beyond behavioral health, too, and as we heard one woman say, if her doctor does not have the answers, she'd rather go down the hall and find out from someone else, rather than wait two weeks to complete the referral (and have that doctor only spend two minutes with her).

The sentiment is strongly in favor of integration, and the best next steps are to remove any barriers for clinics to fully integrate in terms of billing policies and the like. Patients greatly desire a seamless interaction with the system, so we should be able to achieve that by keeping the patient's perspective at the forefront of the changes we pursue.

Also, keeping in mind the physical space limitations that some clinics may face, it would behoove the state to elevate their strategies around technology so there is at least virtual integration through sharing communications (either medical records or notes, or actual tele-consultation). The interest from the provider community in this piece seems very strong, and it would be imperative to ensure the smooth implementation of that as well.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☒	☐	We have heard about this being a barrier in rural areas where they have small space in their clinics, and not enough funding to expand their space to add other providers.
Privacy Laws (HIPAA, 42 CFR)	☒	☐	This is a barrier. We think that if patients are engaged, they would have a great deal to say about this that would help the effort to change this.
Professional / cultural divisions	☒	☐	Some schools have begun "integrated training," but we think we ought to also do this across existing professionals who have not been in school for quite some time.
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

The recognition of the whole person is so important, and many creative solutions exist. Standards are important, but what is equally important is balancing those standards with room for innovation, so providers can do what they do best in a way that is most suitable and preferred for their patients and their communities. We recognize that different communities have different cultures, preferences, and strengths, and it is a challenge that we must take up to allow those particularities to shine through as they set out to do good work for patients and communities.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

We recognize that the behavioral health system is lacking in the appropriate workforce, so HCPF's help in getting more investments for that system would be significant. DHS should have the collaborative support of other agencies as they try to gain awareness and traction on their needs.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

Care coordination means coordinating patients across all points relevant to their care. This includes referrals to specialists and other provider types (e.g. behavioral or oral health) as well as assisting patients in addressing their social determinants of health challenges.

b. How should RCCOs prioritize who receives care coordination first?

We are not certain of the best approach to prioritization, but we know that there have been attempts at two approaches that seem logical. One approach entails patients who are accessing care in inappropriate settings, e.g., calling 911 for non-emergent needs, being readmitted to the hospital, going to the ER, and getting set up with a care coordinator who will screen them to figure out what it is they need and guide them through the system in that way. The second approach involves taking into account someone who could potentially become at risk for these behaviors, so they can learn how to navigate the system appropriately before they are high-risk.

There are exceptions to this, of course. There will always be people who "spike" in their usage of the system, not because they do not know how to navigate through the system, but because their health conditions have given them enough trouble that they have to over-utilize the system for a short period of time before they return to health. We need to be sensitive to those patients and give them care coordination resources as well, while working to understand the full picture. The important thing is to be empathetic to the patient's whole experience.

c. How should RCCOs identify clients and families who need care coordination?

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

There are social determinant of health resources that care coordination does not always seem to incorporate, but the evidence is clear on the need. This is a huge determinant in a person's health experience, and we should integrate this throughout the system.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

As aforementioned, it is important to acquire an understanding of a patient's entire experience of health. In order to know what kind of care coordination a patient requires, it is valuable to be aware of their lived experience outside the walls of a clinic, such as housing and one's ability to access adequate nutritional sources, and how this impacts their health care. We heard in one focus group that a patient was facing a severe health issue in the emergency room, and when she had arrived home afterward, she found that her heat had been turned off. She knew she qualified for a medical exemption, but could not get the needed support from her health care provider to achieve that. She could not recover well at home because of her inability to get her needs met external the medical system, and had to rely on the assistance of her sister who fortunately lived close by. Care coordination resources could have helped her navigate the system more successfully.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

We are aware of EMS/paramedics who are working as patient navigators and community paramedics in a few communities. This is a somewhat new effort, but communities are recognizing the gaps in health care and leveraging existing resources to ensure that their communities' needs are being met. There have been some great results, from reduction of emergency room utilization to lower hospital readmissions.

We also know about *promotoros* and other community health workers (that have a variety of names) who are doing good work. They are trusted community resources who successfully help patients arrive at the most appropriate access points in the system and help them navigate health care visits. There are hundreds of examples that CCMU hears about, ranging from the Bridges to Care project in Aurora to the Be Well Stapleton block captain model, and from the Center for African American Health fairs to the Native American "sisters." They are all accomplishing incredible things within their own communities, and we could learn a few lessons from them.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

RCCOs should leverage existing relationships rather than duplicating or disrupting them. Community resources have brokered trust over a period of time, so it should not be the RCCOs role to replace those resources.

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical	Should the	Should the RCCOs	Should the RCCOS have an additional role

need:	RCCO have a role?		coordinate with community supports and services?	beyond coordinating with these supports? If so, what should that role be?
	Yes	No	Yes	
Abuse, neglect, and trauma	☒	☐	☒	
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	
Daycare / childcare	☒	☐	☒	
Economic stability & employment	☒	☐	☒	
Education	☒	☐	☒	
Environment	☒	☐	☒	
Food access / nutrition	☒	☐	☒	
Health literacy	☒	☐	☒	
Housing	☒	☐	☒	
Language or translation services	☒	☐	☒	
Literacy	☒	☐	☒	
Transportation	☒	☐	☒	
Other	There are many social determinants of health that CCMU has studied, which are referenced in our video and materials (www.ccmu.org/sdoh). We think that the RCCOs should have a role where appropriate and where there is a gap, but if there are existing community resources, the RCCOS should simply leverage the resources and ensure that patients are able to use the best resources to their advantage.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Please type your response here. We believe that the best care		

coordination is determined by the community and who the patients trust most. We do not think that specific requirements will aid in this tactic. Keeping it open to community innovation will enable them to do what they think is best.

17) **Care coordination requirements for specific populations**. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

Perhaps we should first define why we think we need care coordination. Is it because the data tells us that care is fragmented? Is it because people are over-utilizing more expensive and less appropriate sources of care? Is it because we know there are high rates of non-compliance among patients? Whatever the data is, we should use that as our evaluation tool, but also continue to collect stories. Bridges to Care seems to have figured out a great model of combining quantitative data analysis with individual stories so they can understand their impact on the patients they have engaged through their process. This kind of model should be deployed for measuring the impacts that we want to measure through care coordination.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐

2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Clearly, we would have to look for existing relationships in the community and indication of past experience in problem-solving in a community-collaborative way. CCMU knows the Colorado Network of Health Alliances (28 locally-formed health alliances with the intent of collaboratively addressing local health systems issues using local strengths) would be a key player in determining whether a bidder has that strength.

Moving forward, a bidder would need to recognize that a RCCO is not there to duplicate services or take services away from the groups who do the work well already. Rather, a RCCO does its best work when it leverages existing community resources in a more coordinated way. It would be a requirement that the RCCO assesses the community for work already being done before starting a new project, and engage through a community advisory board or a community stakeholder meeting to best understand whether a project is suitable or if it should be tweaked to better fit the community.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This seems like a good idea from CCMU's perspective in an attempt to eliminate some of the confusion that RCCOs currently experience in having their clients across RCCOs. This seems to us like an alternative to number 24, where some key elements are standardized across RCCOs. If there is community push-back to that standardization (and this would be beyond the providers, too), then this proposal would be the better option, so communities can maintain their unique nature in each RCCO, but providers don't face the challenge of working with multiple RCCOs that move operationally in different ways.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. We think that there have been some challenges in how certain communities often prefer to collaborate across county lines, but in this most recent iteration, have been assigned to separate RCCO regions. For example, Larimer and Weld counties have worked together in the past, but were separated in the regional map. Again, CCMU's management of the Network of Health Alliances would be a great resource to leverage to better understand how communities define themselves. We also recommend an analysis, if possible, of care patterns of patients to understand how they determine their own communities. Many residents may seek care in the places where they work, and not where they live, or

vice versa, so it would be important to have the data guide us in this matter. However, ultimately, we believe the maps should change so it is far easier for patients to navigate through their regional system.

28) Should the BHO region maps change? Why or why not? If so, how?

We think it should be aligned with the RCCO maps, as it would make integration far easier. Providers can "talk" to each other across the same regional lay-out, rather than overlap multiple regions in the other system. This should eventually move to one system, but before we get there, we should align the maps.

We also think the same suggestions we inserted into question 27 should be considered here.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

We heard from one focus group that the participants faced challenges in understanding what their Medicaid benefits included, but are told that they cannot use all their relevant benefits with a provider who they are seeing. For example, they knew that varnishes were covered through their kids' dental benefit, but the dentist they visited would do cleanings, but would not do varnishes. We are not sure what the solution is – whether it is having the providers be up-front with what they will treat and will not treat (and in the latter case, make referrals to others who are willing to do the treatment) or requiring providers to do all the treatments that the patient is covered for and the provider is trained for.

Other than navigational difficulty, we heard that in general, the Medicaid benefits seem to be pretty satisfactory. Some focus group participants wished that more cosmetic benefits were covered; however, in terms of medically necessary benefits, they were pleased with their ability to get their needs met.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

This is an interesting idea. CCMU does not have an opinion one way or another, but wish that the above items will be addressed or considered if HCPF does choose to move in this direction. Also, we know there are advantages and disadvantages to competition—competition could drive more innovative and forward-thinking action, or it could drive down quality. We suggest that national research be engaged, and the literature be heavily consulted before going in this direction, as this would be a major shift from the way it has been done in the past, and this is not a decision to be taken lightly.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

RCCOs should assist in helping to find the PCMP that would be right for the client (without "favoring" any PCMP over another). This could involve an evaluation of what that PCMP specializes in (e.g., population-based care, such as kids versus adults, or high-needs adults) so that clients can find out what best suits their needs. Also, RCCOs should discover the client's preference for finding care, such as near their workplace or home, or along a certain bus or train line, so they can easily get to and from appointments, or open certain hours. Perhaps RCCOs can come up with a "short list" for what clients should consider using as their PCMP and what the reasons are for those on the short list, but not strongly recommend or encourage a particular PCMP selection.

If a client is unhappy with their current PCMP, RCCOs should certainly help in finding one that is a better fit for them, and RCCOs should discover why the client is unhappy, to understand if there is a need for changes in how the provider treats his or her patients.

We would also encourage the Department to consider the reasons for the attribution process and to see if there would be a better way to measure clients' linkages to a PCMP. It appears to us that the loose definition of attribution is less helpful, when you measure everything from the client being sent a letter to the client actively signing up with a specific PCMP. If the goal is to measure client's "medical home-ness," then we encourage a stricter definition of attribution so we know exactly where our gaps are in creating medical homes for clients.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

As CDPHE has an impact on (potential or existing) oversight of patient navigators/community health workers, community paramedics, and local public health agencies, the collaboration should be tight. Staff from CDPHE should share their expertise on what local community resources should be leveraged throughout the work, and what lessons can be learned as we move through the next iteration of the ACC. Often, we see CDPHE staff attending ACC-related meetings, but not contributing actively around their experiences from the groups they regulate. We think there is a missed opportunity here that should be seized moving forward.

Leadership at CDPHE has shown a great commitment to the SIM process, and as the core element of SIM, integration of behavioral health and primary care, is a core piece of the ACC vision in the next iteration, it would be useful if leadership could also show the same commitment to the ACC vision. This could assist in a more thorough partnership between the two agencies.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

We heard that some community paramedics are paid through the RCCOs as well as through some DHS programs, so there is definite opportunity for tight collaboration here.

Also, if we are truly committed to integration of behavioral health into the ACC model, it is imperative that DHS is involved. We think this is similar to our response in number 35.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

HCPF and the RCCOs should regularly visit with patients by developing relationships with local housing organizations, family resource centers, other direct service agencies, and community organizers. There is a wealth of opportunities to leverage for stakeholder/patient engagement. CCMU went on a mini-listening tour with 3 focus groups, and we leveraged the relationships we had with these types of organizations. We hosted dinners at existing meetings or times when they usually gather, and made sure it was after work hours. The groups were heavily attended – we had between 9 and 16 people at each group, and it was powerful. We also started with the frame that we genuinely wanted to listen and learn about their experiences and we would keep their names confidential. This allowed them to trust us enough to share in very personal, sensitive health care experiences. It was powerful. While CCMU is happy to do this (as this is part of our work), we strongly, strongly encourage both HCPF and the RCCOs to do this also.

From what we have observed from early RCCO attempts at stakeholder meetings, it seems that hosting town hall meetings does not work. We would advise meeting people where they are to engage them properly, rather than inviting them to a meeting.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

We are not certain of what the "specific" requirements should be, but there should be substantial and meaningful engagement with each of these stakeholders on a regular basis. Again, we think the best strategy is to go to them and frame the conversation as one where authentic listening will take place. It would be most beneficial if RCCOs regularly checked in with them to not only understand the breadth of everyone's experiences as they participate in the ACC, but also to leverage their expertise on key decisions that will affect them. Here, what is important is listening to them, as opposed to pushing hard a strategy or a change upon them. We recommend trying to guide them through what you're thinking and genuinely get their reactions, and to the best of your ability, incorporate what the majority says. This process will encourage everyone's full and positive participation with and commitment of the ACC.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

Again, our answer to this question is the same as numbers 39 and 40.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Again, our answer to this question is the same as numbers 39 and 40.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

No, we believe that it is currently not adequate.

a. If no, what are the gaps?

We know that the PCMP networks are moving toward adequacy, but are unsure yet if it is quite there. As far as the other essentials, specialists, behavioral health, dental, and non-medical providers, we do not believe that they are adequate and there is much room for improvement.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

We have the opportunity to be closer partners with the hospitals in the next iteration. We know the ER rates are high, and the hospitals could contribute significantly to reducing that rate. They can deploy partnerships with community navigators, community health workers, or community paramedics to reduce ER visits. They can try to work with patients to encourage more appropriate access, while understanding what drives patients to the ER. Is it related to transportation, or the hours or long wait times at the PCMP, etc.? That information can inform other system adjustments we need to make.

b. What role should pharmacies play in the next iteration of the ACC Program?

We know that in some rural communities, pharmacists are the most trusted health care provider and health care resource. We should acknowledge that and leverage that by seeing how they can best educate the patients they come in contact with in order to encourage better health behaviors, and also connect patients with other community resources they might not be aware of.

c. What role should specialists play in the next iteration of the ACC Program?

Specialists in the next iteration will be significant. This has consistently been a challenge throughout the last few years of the ACC as well as historically for general Medicaid access. We continue to hear that PCMPs are frustrated with the inability to successfully refer patients to specialists because it is not guaranteed if the patients will be seen, so it discourages PCMPs from participating in the program.

To fulfill the vision of a medical neighborhood, we desperately need specialists' participation. HCPF's attempts to pilot some technology interventions, like e-consult, will be significant to encouraging that participation.

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

Counties have a real opportunity that we believe is not being taken full advantage of, but we have long recommended. When counties assist with the application, they have the opportunity to educate clients on what to expect in terms of communications from HCPF and next steps for getting their care. It would be so impactful if the counties told clients what to expect in the mail from the ACC, and what to do after they get their enrollment information, so clients can most effectively leverage the ACC and the resources there. This way, the clients open the letters they receive, and can trouble-shoot if they somehow miss a piece of mail that they were expecting.

h. What role should local public health agencies play in the next iteration of the ACC Program?

Local public health agencies are a trusted resource of many who are vulnerable to poor health, and much like pharmacists, we see this especially in rural areas. This should be a resource that we will rely on to help patients be navigated to the right resources, as well as raise patient education levels on healthy behaviors.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

Much like what we have inferred throughout this RFI, there are many trusted touch points already embedded in the community that we should appropriately leverage moving forward. If patients trust a certain health care resource, we need to elevate their knowledge of how to navigate patients through the system and use their benefits. Rather than reinventing the wheel in terms of new health care resources, we need to ensure that we use existing ones that patients are already well-connected to.

As mentioned in earlier questions, EMTs/paramedics are starting to branch out as patient navigators and community health workers in some communities. We have learned about their work and are very supportive of their innovation as it is a creative and effective solution for some

of the medically underserved. Just like we hope that innovations are an option in the RCCOs moving forward, we would hope that these EMS groups will be included.

45) How can RCCOs help to support clients and families in making and keeping appointments?

First and foremost, listen to the patient. If they say that their challenge in making and keeping appointments is transportation, then we need to figure that out. If they say their challenge is getting through a long waiting list, then that's where the focus should be. We see the RCCO being the cornerstone of all these community initiatives and community resources and the RCCO should see how things can be woven together to benefit the patient where there are challenges, and where investments and energy should be focused to address other challenges.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

We believe that communities know best about what innovations they would like to leverage. Some communities have benefited greatly from innovations like community health workers and/or patient navigators, and we have seen other communities benefit from EMS workers acting as patient navigators or community paramedics. We do not believe the time is right yet for this to become a requirement, but rather, an option for communities to pursue if they find it to be the most effective tool in their toolbox.

47) **Community Health Worker reimbursement**. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

Since HCPF has contracted with an ACO to manage the dental provider network, we believe it is their responsibility to ensure an adequate network of dental providers. However, it would be useful if the RCCOs could ensure that communications about dental benefits and available dental providers are shared with patients so they can access the oral care they need. Eventually, we should move toward integration of oral health into the RCCOs. We know the timing may not be right at this time, since we just chose an ACO,

but having some of the structures in place soon so we are better prepared for the eventuality of integration writ-large would be strategic.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

Cultural competence means that the patient's specific culture is taken into account as they move through their treatment. It also means being aware of what the patient would respond to, given their particular norms and preferences.

b. What RCCO requirements would ensure cultural competency?

One very clear way to get to cultural competency is to encourage hiring of multilingual personnel at all levels of the ACC: throughout RCCO staff, all provider types, and other resource contractors from the RCCO (e.g. community health workers and care coordinators). When we visited a Spanish-speaking focus group, they told us the most challenging part was getting through the system when no one in a medical office speaks their language. We also know from other patient stories that telephonic interpreters dramatically change the care experience and lower the effectiveness of the care provider, just because the provider cannot directly speak with the patient.

Other resources RCCOs could offer is for providers to be trained in specific cultural understanding. For example, if a provider happens to serve a predominately African-American community, having an understanding of their culture and preferences would be useful.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

RCCOs could offer seminars around plain language and creative tools on how to work with and address patients who have low health literacy.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐

Others	

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☒	☐	
Focus groups	☒	☐	When CCMU did our focus groups, it was incredibly powerful. We highly recommend HCPF to do this by partnering with folks to attend resident council meetings or parent-teacher trainings at family resource centers, and going when it is the right time (after work hours) for them. Qualitative data and stories are so critical to understanding their experiences. If you do decide to pursue any quantitative data, please do combine it with qualitative interviewing or focus groups to get the full picture.
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

Tracking ER data is wise, though, we suggest that the data be sliced further to understand more about patient behaviors. Are patients going at a certain time of the day? Are they going for certain conditions that we know should be seen at a PCMP, but perhaps they don't see it that way? It is important to understand that patients may have rational reasons for why they are going to the ER, and what this means for our work within the system.

Other population data is important, such as chronic condition measures, behavioral health measures, etc. However, we need to be strategic to capture the diversity of the patient population. Not one measure can tell us the whole story of all 700,000 within the ACC, but many data across many different populations can help us. For example, children health measures are very different from adult measures, so we need to ensure that the data measures we have can capture the child health experience in the ACC apart from adults.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment**. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐

Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☐
Care management tool	☐	☐	☐	☐	☐
Care transitions alerts	☐	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☐
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

81) How can Health Information Technology support Behavioral Health Integration?

Health information technology could be significant in behavioral health integration, so we can maximize the current workforce we have in the short-term, while making long-term investments to continue building and enhancing our workforce. We think this could be done for consultations, referral communication, as well as provider-to-provider education.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

Colorado Coalition for the Medically Underserved

Medicaid Focus Group Engagement: Mercy Housing Decatur Property, Denver
November 11, 2014

CCMU visited Decatur Place and had the opportunity to talk with 11 residents. These residents live at the Decatur property of Mercy Housing, an affordable housing organization, and all women are low-income, single, and have children. CCMU asked general questions about the women's experiences with Medicaid as health coverage, their ability to access health care for themselves and their families, their ability to navigate the enrollment system and care system, among other topics.

As best as we could, we have listed direct quotes organized by topical area for best understanding, but not at an attempt at interpretation or theming. Where we could not write out direct quotes, we have done our best attempt to stay true to their message. We also promised confidentiality, so no names are listed below. Each bullet point identifies a different speaker, though many of them chimed in multiple times throughout the conversation.

Administrative navigation

- "Medicaid is confusing. Up until September, I was covered through my mom, which laid out who I can go to for care. With Medicaid, I can't get a straight answer on whether someone can see me, but it's easy for my daughter. We can just go next door for her care."
- One woman has Medicaid and is a member of Denver Health. She chose to do that, but it is confusing because this is her first time having Medicaid and she is a first time mom and she wants to get her tooth fixed. Sometimes they say they won't cover it because she's over 21 but sometimes it can be covered because she has a baby. She has a tough time knowing if they will cover it, especially as a member of Denver Health. She said: "It seems like they're confused about my benefits because I'm over 21 and I'm a mother."
- "I am on Medicaid and it took me four years to get a Medicaid card and I have applied for one four times. I want my own copies because I don't know where to take my kids, and I haven't even had one for myself."
- "I used to live in Jefferson County which was really difficult but now I live in Denver and it's a whole different ball game."
- Someone else said with Medicaid customer service, you wait a very long time and may not get what you need.
- "If you are not on top of recertifying your stuff, it becomes a real mess."
- A number of residents shared their experiences about eligibility confusion with family members, and others being shifted and changed from different accounts.
- "The county system is complicated."
- "Sometimes it's a pain — in Jefferson County, if you aren't on top of re-certifying your stuff, then you have to take the day off to get it done."

- A participant said about change process of how long it takes to get Medicaid: in Jefferson County, it took 3 months (but another woman said it took her two minutes)
- Arapahoe County is difficult. One woman was pregnant and applied for Medicaid. "I had open Medicaid but they closed it before I became pregnant. They didn't approve me when I went to Arapahoe County, and it took me a month to close that case and I moved back to Denver and it was easy after that."
- Making the transition between counties easier (but two women said they had lived in a different county—Weld and Adams County—and it only took a phone call to switch everything). In the midst of switching, one had to pay $200 for health care needs she had in the transition period.
- "I was told that I could apply for my daughter in November after splitting from the child's dad and they said no, she's on his, and he didn't list my name on the application." She reported that it has been a difficult process sorting that out.
- "I have heard of a RCCO but I wouldn't be able to give you a definition."
- "I don't know ACC, but I can Google it."

Behavioral health integration

- "It would be great to have everything in one building like Kaiser. All you need to do is go there. The convenience would be great with everything you need under one roof. They would have the answers to other questions under one roof, and you wouldn't have to wait two weeks to get an answer. Let's say you are going to one doctor and they want to talk to someone else. It would be nice if within ten minutes you had your answers."
- "The same place would be much easier than just coordinating services."
- "My son now has the PCMP I had when I was a kid, so I still see her. I tell her everything and she helps me through things without medication…she's kind of my therapist."
- One woman said her psychiatrist caught her attention because he would directly get involved with everyone; she heard about people having contradictory medicines. She said: "Contradictory medicines between psychiatry and primary care is problematic."
- "Each care provider has their own specialty and that's the way it should be."
- "It's important for doctors to have that awareness of mental health concerns but recognize when that's not their strength and know when to refer; they need to have that real understanding of how it interacts with other prescriptions you may have."
- "I forgot my midwife wasn't a doctor [chuckles]. She sees me for all my lady needs. I had a therapist come in right after I had my baby to make sure I didn't have depression, and they are all connected to the hospital, which is good."
- "It needs to be joined, but Medicaid should be responsible for having the proper qualified people providing care."

- "Being diabetic and having anxiety makes me eat what I am not supposed to eat, which affects my diabetes, but if I don't eat, I go through depression, because I like cheesecake. I need someone to help me boost my motivation to be healthy."
- "I recently got really involved in my mental health because of MHCD, and they were much more helpful than Medicaid. When I found places where I was interested, they didn't even take Medicaid."
- One woman stated that coordinating would help, because "you don't want someone to say 'go take care of this' and you go do it and it's not even right."

Experiences in care

- "During my pregnancy, care has been consistent but before that, the last time I went somewhere was when I was 6 years old. Medicaid gives me benefits but only through subcontractors, so I have to go through them, making the care feel disjointed. But care isn't disjointed for my kid. It's a piece of cake."
- Another woman said that she has never had a problem getting the care she needs. She has been on Medicaid for a long time, since she was 10 or 12 years old. "It is convenient, but they only give you certain opportunities of places you can go to receive care. Sometimes it is inconvenient. We go to the dentist on 14th, and my son's tooth chipped, and they wanted to send him to Parker, which was super far, and inconvenient, because I would need to take the bus. It is tough, because it is hard to know what you are covered for and who you can go to. It can be confusing and kind of hit or miss. I'm confused; the papers I get are not too self-explanatory."
- "I want a case management approach of people being there to help, so something like a nurse family partnership."
- "Medicaid wouldn't cover a shingles injection, after I was exposed to it, because I'm not 65. They could only give me the pills if you are exposed to it, but there are people my age who have shingles. I was exposed, and the pills don't seem to work as great."
- "If there is one thing you can do, put circumcision back in Medicaid. I don't know why it was taken away in the first place. Without it, babies are at a higher risk of getting infected, because it wasn't covered... I mean, kids don't want to stay clean!"
- "I had the best care provider at West Side, but then they switched me to Denver Health, where I hated it because they made me wait so long."

Emergency room use

- "They [primary care] should stay open after hours. After all, how can you get your kid in for her annual visit when you have to work? My only choice is the ER."
- "I use the ER a lot because of my work schedule."
- "I use the ER sometimes because of location – I went fishing and my daughter had to go to the ER, and Medicaid covered most of it."

Specialty care and dental

- "It's easy to get a specialist for glasses and for dermatology, because my diabetes is messing up my skin, but I have to wait 2 months just to see a specialist only to see them for 2 minutes when I need medical attention."
- "Dental benefits on Medicaid are good. The dental side of Medicaid seems more on top of their stuff than other services."

What works

- "Preventive care is better than letting it get to the point where it is $5000 out of pocket."
- "If you need one prescription, they cover it. Maybe you have a little copay, but it's better than paying way more for that."
- "You need it; they'll cover it. There's a little copay, but it's good."
- "I got my Medicaid within 5 minutes. I got it before I even got my SNAP card."
- "I love my baby's doctor, they call my baby 'friend'."
- "My daughter has sickle cell anemia, and they treat her like top priority at the doctor's office."
- "At the downtown women's clinic, they take really good care of me as a high-risk person."
- "My nurse is the most trusted person. Others never give you a straight answer, and they say that the information is in your Medicaid package."
- "I went to a family nurse partnership and she was super helpful but other than that I was calling a bunch of places. I tried to get contacts the other day, and had a difficult time doing that."
- "The nurse family partnership is consistent, gives full attention, weighs the baby, and does just about everything. She's the main person that helps me know that my baby is okay. When she didn't know something, she went to her supervisor, and when things weren't covered by Medicaid, she would give referrals to other places."
- "Anything you need, she [the nurse] does it.... She went with me to my appointment and helped me."

What should change

- "I just stay there [at Denver Health], and don't move. I don't want to take any risks."
- "I saw a provider and he put me below the belt. Because I am a Medicaid recipient they throw me in the dirt. I see how they treat privately insured people, they get treated like royalty. Regardless of how I am insured, I am insured. Medicaid is insurance. There is no reason to feel discriminated against."
- "Nobody is a trusted source of information. No one gives me a straight answer... they're not helping us understand who we can go to."
- "I'll call here and I'll call there. I jump through all these hoops and I still can't figure it out."

- "Don't make me go all the way to St. Anthony's when Denver Health is close."
- "I want something like Denver Health but closer!"
- "Is there a difference between urgent care and Medicaid?"
- "There is definitely a lack of trust. It's so confusing. It seems like it changes all the time on us."

Colorado Coalition for the Medically Underserved

Medicaid Focus Group Engagement: Together Colorado, Aurora
November 12, 2014

CCMU visited with six participants and five volunteers of the Bridges to Care program in Aurora with the help of Together Colorado. Bridges to Care is a program funded by CMS Innovation grant to match care navigators with patients, who were experiencing highly complex health issues and appeared to not get their needs met (as evidenced by high hospitalization rates and high emergency department overutilization). Bridges to Care provides willing participants with 60 days of multi-disciplinary team-based health care, including care coordination and linking patients to primary care.

As best as we could, we have listed direct quotes organized by topical area for best understanding, but not at an attempt at interpretation or theming. Where we could not write out direct quotes, we have done our best attempt to stay true to their message. We also promised confidentiality, so no names are listed below. Each bullet point identifies a different speaker, though many of them chimed in multiple times throughout the conversation.

Navigating the system

- "For health care to work, you need to know the system, because then you will get what you need. If not, you will be 'played with' by doctors, administration, etc. People who I have interviewed, when they know the system, they say it is easy to get care. If they don't know the system, they say it is not easy to get care. Knowing the system can range from knowing how to talk so that you are heard or knowing where you can go to so that you get the right help, or knowing how to use the two to get what you need. If you are clueless, like fellow immigrants with a language barrier, they don't know where to go or who to talk to or how to talk."
- "Sometimes you can't even get past the secretary to make the changes you need to make."
- "I had a very bad day today. My sister called me. She had just left the ER on Saturday, and they said they found blood in her brain. At the ER, they told her to call a family member, and she wouldn't at the time, but she called me finally and asked for help. When she got home from the hospital, she found that her electricity had been turned off. I called University of Colorado Hospital and everybody was so rude. I wanted their help getting her heat back on. Excel Energy is asking for a form to be filled out and nobody will fill it out because they are saying this other doctor saw her, but when we tried to get the doctor's office and drove to UC Health, even with my connections, I couldn't do anything. They were so unhelpful. She was poorly treated, especially when we told them she doesn't have insurance."
- "I lost my job, and the harassment you get from the games they play makes it hard to get help for things, like lighting. For heat, maybe there is a little help. If health systems could give you connections to those social determinants of health, that would be great. I needed to go on disability, so I needed a letter, so I didn't have to volunteer, and it was easy to get it from my PCMP, but then it goes through this crazy administrative process."

- "It'd be awesome to have those other supports, especially if you need a signature from someone in the health care system."
- "If there was someone like a social worker who could evaluate people and their needs, and what they are eligible and not eligible for, and then direct them to those agencies, then that would be great. I am not sure how to address it with people with language barriers though. An initial evaluation would be a step forward."
- (As translated into English) "I've been here for 5 years, and used to have benefits with Kaiser. When I lost my insurance, four months later, I felt sick and I went to the emergency room. I had to wait for a long time, and after an hour, someone went to get me and see me. They did all these tests, and then gave me a bunch of pills. A few weeks later, I get the bill. It was $4000. I wondered why I needed to pay $4000, so I called them, and told them I had no insurance and no money. They said that's my bill. I didn't know I could apply for Medicaid, because I didn't have that information. With the bill, I even called people back home to ask for help to pay, and that's how I found out that I could apply for Medicaid. I didn't even know how to start applying, and a friend of mine gave me number [of a Bridges to Care volunteer navigator], so I went to see her and she asked if I was legal here. Since I am, she took my paperwork, and then she applied for me online. I then had an emergency, so I had to travel back home, and spend 3 months there. When I came back, I found the letter saying I was enrolled in Medicaid. I called them three days ago, and they told me they sent me a Medicaid card in the mail, but I never saw it. People need to be informed, because if I wasn't sick to go to the doctor, and then received this bill, I would've never known that I couldn't apply for public assistance with Medicaid. I found out I could see the doctor, and I wouldn't really pay anything, and I thought that Medicaid is a good thing."
- "If the state could do something better, it could give better information."
- "How does it work to get appointments in clinics? Is it prioritized for a reason? Can they even tell us?"
- "I want a central location for information and direction."

Care experiences

- "My biggest thoughts about health care and how it's managed, and the fact that it is not managed is that you go to a primary care provider, and they refer you out, and you're lucky if you can get an appointment 6 months to ten months out. I'm here in Colorado, because I got really sick and I went to a doctor, and not knowing me or my history, as I am a diabetic, he took me off all my insulin and put me on pills. A month later, I was in the hospital in a coma for six weeks. Since then, I've been hospitalized 7 additional times. The one thing that helped me through all that is Bridges to Care. They came to my home, talked to me, asked me what I was looking for, and said how I could get it. A lot of times I didn't have to do anything because they did it for me, and I'm happy to say that even though I'm not 100% yet, I'm much better than when I landed here."

- "Doctors are sparing with their time. They rely too heavily on personal assistance. It takes 3-4 weeks to schedule an appointment. Between the time you schedule your doctor's appointment and the time you show up, it's not uncommon for them to call and reschedule two or three times. Then you're stuck playing phone tag. Is the root cause money? To marginalize and put you into a palliative situation where they just throw lots of medicines at you, and don't monitor you or ask you how you are doing or not doing. Physicians at MCPN make it feel rushed."
- "If something goes wrong with your meds, you have to go to the ER. Because of Medicare price reduction, you get dropped to a cheaper medication and supposedly it's the same thing as the original, but my body thought otherwise. The folks from Bridges to Care got in touch with my doctor, and said this medicine is wrong, and it's doing something it's not supposed to do. Medicaid can't just shove you into the cheaper insulin. It may be cheaper, but it's not great for my health."
- "When a doctor is seeing you, he needs to read your whole chart, and also needs to do specific tests, regardless of the expense of the test to find out the real problem. And they need to talk to you if they plan to change your prescriptions."
- "They [doctors] need to make connections to what you need."
- "Pharmaceutical companies need to get out of the business of diagnosing people they haven't seen before."

Specialty care

- "Getting in to see a specialist is easy, since you can just go to the hospital. But getting primary care is really hard. I sat on a waiting list for 6 months, and Bridges to Care helped me with primary care access."

Benefits of Bridges to Care:

- "Bridges to Care put me right in the seat after 9 years of congestive heart failure and in a short period of time it was all done."
- "Bridges to Care is a good stop-gap measure. I've seen them [MCPN] go down steadily since the 1990s with doctor turnover. You often end up with PAs when you can't get in to see a doctor. You have to bring your own records, because they call in your medication wrong and you won't even know. They helped me with insulin, and the referrals they give you have to come from a doctor, because the doctors aren't there, so it takes forever to get a referral, and that's not counting the waiting list at University Hospital. It's scary and it's getting scarier, because people are waiting and it's getting worse."
- "Most things that are working well had to be supported by an outside group; it takes some sort of systems approach to help with that."
- "When I first came here [to Colorado], I went to this doctor and got into Bridges to Care. Through the multiple hospitalizations, I questioned the fact that I was a type 2 diabetic. I got tested and found out for 20 years I've been treated as a type 2 diabetic when I am actually a type 1. That in itself was scary. The people at University were at a loss as to

why some other things were happening to me, and I think my body just dealt with it until it couldn't anymore, leading to hospitalizations. Now I'm back into recovery. Everything I've needed is due to the stuff I'd been through, having moved to Colorado, and just feeling lousy all the time. The people at Bridges to Care actually care about how you feel. One of the nurse practitioners is amazing. She actually listened, which made a difference, which is a big problem with doctors. I've been in situations where a doctor and a pharmacist were doing my appointment, and my doctor was in and out and on his phone. He wasn't fully present."

- "At Bridges to Care, they do health care *with* you instead of telling you. They can help you with some of it but the rest is up to you which is good."
- "They really hear what you say, which makes a difference because you know yourself well and everybody is not typical."
- "Bridges to Care gets at some of that [patient navigation and supports]. They want to look at the whole picture."
- "At Bridges to Care, the nurse looked a lot at my medications, and made some decisions with respect to the dosages. They tried to figure out what I really needed. She is very alert, and they look at the whole person."

Behavioral health

- "Bridges to Care is connected with many different mental health organizations, and I go to Aurora Mental Health. I worked as a nurse for 20 years, and I'm only 59 years old, and I can't work anymore, so I have anxiety and overwhelming depression."
- "Any type of consolidation is good, so you don't have to run all over the city."
- "Please don't have Medicaid be with Kaiser, because Kaiser doesn't accept behavioral health from Medicaid. You are on your own, which is outrageous."
- "I have a lady who calls me once a month and asks how everything is going, which was very helpful."
- "A one-stop shop would be great."
- "Consolidation would be great because doctors are not getting the whole picture when they work in different places."

Dental health & care

- "You have to go to the University dental school and see if you are eligible to get treated for a root canal or infection."
- "I knew that Medicaid just added dental care for adults under DentaQuest. Prior to July of this year, if you had oral issues all you could do was pull the tooth out."
- "My daughter just got approved for a wisdom tooth removal."
- "I go to Comfort Dental and Medicaid doesn't even pay for cleaning anymore but they said they could send a request letter to them and see if they could approve it to pay a sliding scale fee."

Colorado Coalition for the Medically Underserved

Medicaid Focus Group Engagement: La Familia Family Resource Center, Fort Collins
November 20, 2014

CCMU visited La Familia Family Resource Center in Fort Collins. La Familia provides a variety of services including Family Strengthening Services, Healthy Living Programs, Early Childhood Education, Youth Programs, Adult Education, and Resource Referral. This focus group was conducted with 18 participants in the Parents as Teachers (PaT) class, mostly mothers and one father. Not all participants were covered by Medicaid, but the majority uses the system either for their children, themselves, or both.

CCMU asked general questions about their experiences with Medicaid coverage when applicable, their ability to access health care for themselves and their families, among other topics.

As best as we could, we have listed direct quotes organized by topical area for best understanding, but not at an attempt at interpretation or theming. Where we could not write out direct quotes, we have done our best attempt to stay true to their message. Almost all of the focus group was conducted in Spanish, with the help of a translator of the staff of La Familia, which made this especially tricky for directly quoting the participants.

We also promised confidentiality, so there are no names listed below. Each bullet point identifies a different speaker, though many of them chimed in multiple times throughout the conversation.

Navigating the system of care:

- About half of the participants in the room the room said they had a provider they liked and visited regularly.
- In the Salud Clinic in the area, the providers are great. It is the receptionists who are rude, and have a poor attitude.
- Parents went for a physical for one of their children, and asked if the providers could see their other two children as well because they were sick, and they were told no.
- One participant brought her daughter to the emergency room for an ear infection, and was given antibiotic drops. The ER staff said that they should follow up with their primary care provider in three days. But they wouldn't see her at Salud in that short notice, so she had to go back to the ER.
- "They told me the same thing. To follow up within three days. But at PVP [Poudre Valley Hospital, which is now University of Colorado Hospital], even if I call at about 1:00 in the afternoon, I can see them the same day."
- One participant noted that there are so many people on Medicaid who need care, so people tend to go to places with bad services, because the places with good service cannot support everyone.
- Other clinics are not accepting new patients, so La Familia staff struggle to refer to other locations with better services.

- It is very hard to bring both of one parent's kids into Salud Clinic, as they could not make two appointments in one day.
- "I have the same problem. It is the only bad thing about the clinic."
- "I would change my clinic."
- One participant believed the issue was that the way the clinics are managed are the reason they are so full. They are not efficient enough.
- Other participants believed they just need more clinics in the community.

Using Medicaid benefits:

- One participant said that Clinica de Salud always has good service. She clarified that the physical health care has been good, but dental is not covered by Medicaid.
- Many participants reported that some of the dentists in the community are charging people with Medicaid for services that other dentists are not.
- One woman stated that she had been told by her dental provider's staff that Medicaid has cut down on some of the budgeting for the service, and will cover less now. Others in the room agreed that they have started needing to pay more for their services.
    - NOTE: Participants were asking CCMU why Medicaid had "cut" dental services. We could not answer that question, because to our knowledge, dental has not been cut.
- "I went to the dentist [at ToothZone] and the cleaning was covered and the varnish was not covered so my children did not get a varnish."
- "North Beach [another local clinic] covers everything."
- "I used to go through ToothZone. They told me 'You need to pay for this, and you have to pay for certain amount of things out of your pocket.' And then I went to North Beach and I don't have to pay for nothing. And they recommended me to a good person for my daughter's braces who accepts Medicaid."
- One participant asked if there are clinics where Medicaid will cover everything for kids dental.
- Another participant shared that Mountain Clinic covered braces and all the services her kids needed.
- A participant said that her daughter has three vision visits covered for every year. However, when her daughter was identified as needing vision therapy, Medicaid won't cover it.
- One woman noted that Medicaid won't cover any of the sun protection needed for her daughter's glasses at the same place where they do cover her daughter's visits. The sun protection was prescribed by the doctor.
- Participant said that one of the problems with Medicaid is that it is not accepted all the clinics.
- "Medicaid covers the same percentage of the mental health appointments as physical health. If they cover 20 and I pay 20 for a physical health appointment, they cover the same. If it's 50/50, that's what they cover."

  - NOTE: CCMU believes that they were referring to copayment versus how the clinic is paid by Medicaid. If the patient has to pay 20, the clinic will get 20, and same with 50/50. We were unable to clarify this point.
- One participant asked if she had to renew Medicaid every year.
- "I always receive dos [two] copies of the letters."
- "Sometimes my children have two prescriptions given to them by a doctor of the same medication but Medicaid only covers one. [And he needs to take both doses in a month]. This happens at Walgreens."
- Many participants agreed they wanted better coverage of services in the clinics and the hospital, and better treatment.
- One participant said at the end of the session: "Thank you very much for being here. Sometimes, we feel like things will never be changed. Maybe now they will be changed."

Language barriers:

- One participant shared that the Family Medicine Center does not speak Spanish but has great service. The receptionists are nice and the doctors are very nice.
- "When I was pregnant, I had a psychological issues... they [Salud] gave me phone numbers for a referral, but I could not find anyone who spoke Spanish."
- "I had the same experience at PVP but they were very quickly gave me numbers for people who spoke Spanish."
- "The biggest issue is that the language. It is the only thing."

Perspectives from La Familia Staff:

NOTE: Since La Familia is so heavily involved in assisting their constituents through the system, we wanted to learn their perspectives on how Medicaid is doing.

- "When we call the customer service line for Medicaid, which we do for our clients, we are on the line for hours. We often get disconnected and have to start all over again. It is incredibly frustrating."
- "I do the bilingual application process. The Spanish application is okay. For the most part, the Spanish is okay... I mean, there are some weird things on it. Whether or not, people would be able to fill it out themselves would be based on their comfort with filling out forms... So they write things on the wrong line. They're just not familiar with the amount of paperwork we fill out in our culture. But if you just immigrated here, then you might not know how to fill that out. PEAK, on the other hand, is totally user-friendly... I like PEAK...and they do have it in Spanish. But then we have a problem with computer literacy."
- "I guess I would say my biggest complaint is the wait time. I don't think I have *ever* been waiting on hold for less than 45 minutes minimum. Now, at least I get paid to wait on the phone for people. I cannot imagine how hard it must be for folks that work full-time and cannot afford to take that time out of their day to make those calls. For this, I have a couple of suggestions. Obviously, if there was the ability to hire more phone technicians, that would help things. Also, I called a different hotline the other day, though I can't remember what it was, and they had some sort of system where they would put you on

the waitlist and then call you back when it was your turn. So brilliant! It gave me more freedom to get other work done while I was waiting. Yes, I still had to have my phone on me but at least I was able to leave the room, use the restroom, and other things like that."

- "As far as the technicians themselves, I have had overwhelmingly positive experiences. Aside from maybe one or two people, everyone I have spoken to has been very nice and helpful. The few times that were unpleasant, the DHS technicians refused to help me because my information was not directly listed on the application even though I'm calling from an organization, I know all of the client's personal information, and I list my information on the cover letter when I drop off a paper application at DHS. I understand that they are probably following protocol; it's just frustrating for me because I waited so long and now I can't help the client. There's a form that some technicians have told me to have the client fill out so then I will be able to access that information. However, I cannot find the form anywhere. A technician had to email it to me personally and she only sent it to me in English. Not very helpful. Like I said, however, those experiences have thankfully been few. The majority of the time, the technicians do everything they can to help me and my clients to make sure that everything works out for them. They have all seemed compassionate and like they care about what happens to folks as well."
- "I have also called Maximus maybe once or twice. In case you don't know, this is the company that DHS contracts out some applications to. I get the sense that they are an even larger conglomerate so it's even more difficult reaching anyone from there and those that I have spoken to did not come across as friendly or helpful."

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 090

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Venus Mann, Department of Family Medicine
Location: Aurora, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: University Physicians, Inc.
Location: AF Williams Family Medicine
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Primary Care
  ii. Area of practice: Family Medicine and Behavioral Health
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No

If you answered "yes" above, how long?

☒ 3-4 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:

I have been the key point person for UPI with Co Access and have been actively engaged and represented the PCMPs that are part of UPI

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

I am a participant of the HCPF ACC Statewide Shared Savings Payment Committee

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

Our relationship with CO Access is working extremely well and their organization has done an incredible job as the RCCO for regions 2, 3 and 5. They personify the meaning of care collaborative and their organization has evolved to accommodate all of the changes, has been service oriented and has strong executive leadership at the helm.

2) What is not working well in the ACC Program?

For UPI, we have been struggling with attribution and have been working to find a solution since inception. UPI has a challenging situation whereby we have one tax ID # as an organization but multiple primary care clinic locations that cross separate hospital system we are challenged by tracking our respective membership attribution, tracking our KPIs and dividing up the dollars at the end of the day. We were informed that the enrollment broker, Health Colorado, might have the ability to assign a two digit identifier to each clinic location for clients who call in to select a PCMP, but we've been unable to determine if this is possible and/or affect this change.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

   a) We would like for the ACC to reimburse our behavioral health providers for Health and Behavior (H&B) Codes; we have a fully integrated BH model embedded at AF Williams and are unable to receive reimbursement for H&Bs which defeats the purpose of our model.
   b) For the SIM grant to be awarded to the State of Colorado!

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	Barrier? No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	Reimburse for Health and Behavior Codes or reimburse based on a pmpm amount.
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☒	☐	See above; reimburse for TelePysch.
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☒	☐	A PMPM payment for behavioral health would help defray our costs and assist other PCMPs in their ability to provide behavioral health services
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☒	☐	If Specialists were also paid more favorably we would have an easier time getting our patients access. Additionally, if the Hospital partnered organizations that run our clinics were also paid differentially it would incentivize them to take more Medicaid patients and encourage a level playing field.
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Technical resources / data sharing	☒	☐	Need to incorporate COHRIO data and clinical data to round out data outcomes/data sets
Training	☐	☐	
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

PCMH 2014 Level 3 Recognition or CPCI practice with embedded BH providers.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Pay for TelePsych.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

The best definition is multifaceted and the following lumps care coordination and care management together:

- Attend clinic visits with patients for agenda setting and care coaching.
- Liaison with patients, families, providers, and specialists to ensure adequate and appropriate care.
- Assist with coordination of care and access to care (particularly with UCH specialists).
- Coordinate care with Colorado Access Care Managers for RCCO and AA members.
- Coordinate communication with community providers (APS, Dialysis SW, housing facilities)
- Provide patients with community resource information (Dental, food, MH, financial assistance, etc).
- Housing information (largest social need for AFW patients).
- Arrange transportation via First Transit and Access-A-Ride.
- Assist with transitions of care and necessary medical follow-up.
- Assist with developing Shared Care Plans in EPIC.

b. How should RCCOs prioritize who receives care coordination first?

c. How should RCCOs identify clients and families who need care coordination?

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

There should be a shared platform or a link between our EHR and CO Access' care coordination software. Another option would be to actually embed a care manager in the practices.

12) What services should be coordinated and are there services that should not be a part of care coordination?

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

For the University outpatient practices we are in need of social workers to help arrange services for the RCCO members. Currently there are no resources available for the outpatient clinics.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☒	☐	
Affordability (assistance with prescriptions or co-pays)	☐	☒	☐	
Daycare / childcare	☐	☒	☐	
Economic stability & employment	☐	☒	☐	
Education	☐	☒	☐	
Environment	☐	☒	☐	
Food access / nutrition	☐	☒	☐	

Health literacy	☐	☒	☐	
Housing	☐	☒	☐	
Language or translation services	☐	☒	☐	
Literacy	☐	☒	☐	
Transportation	☐	☒	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	**Coordinate care?** Yes	No	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☐	☒	
Certified Addiction Councilors	☒	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☒	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	

Medical Doctors / Doctors of Osteopathic Medicine	☐	☒	
Nurse Practitioners	☐	☒	
Patient Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☒	
Psychologists	☐	☒	
Registered Nurses	☐	☒	
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	
Other	Care Managers.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☒	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☒	
Children with a serious emotional disturbance	☐	☒	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☒	
Transition-age adolescents	☐	☒	
Parents and families	☐	☒	
Pregnant women	☐	☒	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☒	
Adults with a chronic illness	☐	☒	

Adults with a behavioral health diagnosis or substance use disorder	☐	☒	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☒	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☒	
Frail elderly clients	☐	☒	
Clients in palliative care	☐	☒	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

$6-8pmpm

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

Wouldn't recommend it. Would make payment tracking within UPI too complicated.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐

26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Data reporting; embedding care managers into larger clinics

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

Our outlying clinics (that are part of UPI but operate in other Regions with different RCCOs) would potentially participate but our organization doesn't have the capacity or desire to participate in 3 different RCCOs.

27) Should the RCCO region maps change? Why or why not? If so, how?

It would be incredible helpful to our organization if there was only one RCCO for Regions 1-7.

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

SIM Grant award.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

No, absolutely not.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

A much more active role, particularly for UPI due to our attribution difficulties.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

The PCMPs and the RCCOs should have direct access to communication with Connect for Health Clorado.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

The option to provide a patient navigator embedded social worker/care manager in the clinic itself.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

They should have some sort of skin in the game; especially since our hospital manages and staffs the clinics.

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☒	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

A PMPM.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

See Answers to questions 1-10.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

Yes. We would prefer a separate capitation payment for primary care and additional payment for behavioral health services. The services under primary care would include, but not be limited to:

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

A major role – instead of HCPF.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

Implement something similar to the CPCI project and pay the PCMPs an enhanced pmpm for providing those specified services to clients

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

Being recognized as a PCMH and having clear clinically important conditions that the PCMPs can have a direct impact on other than the current KPIs.

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☒	☐	
Focus groups	☒	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

Need to incorporate COHRIO data and clinical data to round out data outcomes/data sets. Should be tracking patients longitudinally.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐

None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☒
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Ideally yes, but depends on the population age range.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

That's an intriguing idea. It would support skin in the game.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

Yes.

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

N/A.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

The following criteria are considered Key Performance Indicators and if we meet the established benchmarks for performance, we receive a prorate portion of the $1pmpm withhold for KPIs.

- Well Child Checks
- ER Visits
- Hospital Readmissions
- High Cost Imaging

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☒
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☒
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the 5DAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☒
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☒
Patient education wellness tools	☐	☐	☐	☐	☒
Provider/case manager directory	☐	☐	☐	☐	☒
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☒
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

81) How can Health Information Technology support Behavioral Health Integration?

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

84) 5hould there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 091

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Todd J. Lessley
Location: Fort Lupton, Weld, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Salud Family Health Centers
Location: Fort Lupton, Weld, Colorado
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☒ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Salud is a Primary Care Medical Provider in four of seven ACC regions and has formal Care Management delegation agreements with Colorado Access (RCCO 2 and 3) and Colorado Community Health Alliance (RCCO 6). In region 1, Salud has partnered with Rocky Mountain Health Plans (RCCO 1) and delegated the role of Care Management in Fort Collins to an interdisciplinary Care Management effort called the Medicaid Accountable Care Collaborative (MACC) Team.

Collaborative RCCO partnerships allow Salud to insure care is efficiently coordinated and attributed members access a full spectrum of integrated care both in Salud's clinics and the community. Through participation in multiple ACC advisory committees, Salud helps provide guidance to HCPF and RCCO partners on innovative methods of clinical transformation and integration. Salud is committed to ACC implementation and believes that continued RCCO collaboration is essential to the future of health care delivery and Medicaid payment reform in Colorado.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Salud is a Federally Qualified Health Center (FQHC) and receives funding under Section 330 of the Public Health Service Act (PHS) to provide care to underserved populations including Medicaid recipients in Colorado. Salud has a longstanding commitment to the Medicaid population and is the healthcare home to tens of thousands of Colorado Medicaid recipients. Salud is committed to providing medical, dental and behavioral health services are coordinated and integrated to best respond to the needs of each patient.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

The per member per month (PMPM) poyments thot ollow us to develop innovotive progroms not bosed on foce-to-foce visits by licensed providers but insteod bosed on whot potients need to improve heolth ond decreose costs to the system.

2) What is not working well in the ACC Program?

We ore not olwoys sure whot the money thot goes to the RCCOs is being spent on. More money should go to where the work is being performed ond where the innovotion is hoppening.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

The BHOs ore doing o better job of working colloborotively with Community Heolth Centers (CHC). Some ore oheod of others in this regord, but the best ore plocing stoff within the CHCs ond developing fully integroted progroms bosed on potient need, not on odministrotive poperwork like the Colorodo Client Assessment Record (CCAR).

4) What is not working well in the BHO system?

The CCAR is still required ofter o few visits, which ties up provider time ond odds nothing to quolity of core. Some BHOs ore behind in colloboroting with CHCs. We continue to believe thot money should go to where the work is being done. For most potients with mentol heolth disorders, thot meons the money should go to providers working in primory core clinics. It doesn't motter to us whether thot provider is employed by the Community Mentol Heolth Center (CMHC) or the CHC os long os they ore working within the wolls of the primory core clinic. As with RCCOs in the ACC progrom, we wonder obout the volue of BHOs. Are the BHOs necessory ond the odministrotive (overheod) cost of these entities odding volue?

5) What is working well with RCCO and BHO collaboration right now?

It seems to us thot the colloborotion hoppens below the level of the RCCOs ond BHOs. It hoppens ot the level of the individuol institutions. We don't see much, if ony colloborotion ot the RCCO ond BHO level.

6) What is not working well with RCCO and BHO collaboration right now?

See obove

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

The BHOs odministrotive costs move o lot of money owoy from octuol heolthcore, ond offer very little if onything in return. To improve behoviorol heolth integrotion, Colorodo should direct funding towords the institutions octuolly doing the work, including the CMHCs ond the CHCs.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	Barrier? No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☒	*This is nat a borrier far the mare pragressive CMHCs, however funding that should be gaing ta mental health care is being directed ta BHO administrotive casts. To imprave behaviaral health integratian, Colarada should direct funding tawards the institutians actually daing the wark (i.e. CMHCs).*
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☒	☐	
Different behavioral / physical health reimbursement	☒	☐	*Behaviaral healthcare takes mare time and is aften mare camplicated than physical health care, yet it reimburses as a lawer rate. The funding af Medicaid behaviaral and physical health shauld be integrated ta make primary, preventive and behaviaral health services mare efficient and patient centric. The maney shauld fallaw the patient; thus, if a patient receives his/her behaviaral health care at a CHC, the CHC shauld be able to bill HCPF directly.*
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	*This is a borrier, but not a major one becouse we con come up with ways oround it.*
PCMP financing structure	☐	☒	
Per-member per-month amount	☐	☒	
Physical space constraints	☐	☒	
Privacy Laws (HIPAA, 42 CFR)	☒	☒	*In an effart ta enhance integratian and caardinatian af physical and behaviaral healtn and build an effective medical neighborhaad, the department shauld provide direction beyond just the RCCO – Medicaid pravider relatianship. Additianal clarity shauld be pravided regarding infarmatian sharing araund behaviaral health and substance use issues.*

[2] Mare infarmatian abaut these rules, payment types, and entities can be faund in the Appendix at the end af the dacument.

Professional / cultural divisions	☒	☐	*Definitely surmountoble.*
RCCO or BHO contracts	☒	☐	*Colorodo should minimize RCCO or BHO odministrotive costs ond direct funding towords the institutions providing potient core.*
Staff capacity	☐	☒	
State/Federal rules or reporting requirements	☐	☒	
Technical resources / data sharing	☐	☒	
Training	☐	☒	
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

They should meet the integration criteria outlined by CJ Peek, et al. Whole person primary care requires that the entity meet the definition of primary care, meaning that the organization is accountable 24/7 for the vast majority of needs for which people make first contact with the healthcare system. Having a Physician Assistant (PA) in a clinic one half day per week does not make you a primary care clinic.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Be careful about what they call 'reverse integration.' The requirements to be a Patient Centered Medical Home (PCMH) are the same whether one starts as a CHC or as a CMHC. The standard is not lower for a CMHC adding a part time PCP.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

Reference:

- *NCQA 2014 6:B1 "At least two measures related to care coordination"*

b. How should RCCOs prioritize who receives care coordination first?

RCCO's should follow evidence-based guidelines and national standards when prioritizing patients to receive care coordination. Special attention should be paid to vulnerable populations or those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively and presence of chronic illness or disability and include people with multiple co-morbid conditions or who are at high risk for frequent hospitalization or ER visits.

Reference:

- *NCQA 2014 6:A4 "Performance data stratified for vulnerable populations"*

c. How should RCCOs identify clients and families who need care coordination?

RCCOs and delegated practices should establish systematic processes and criteria for identifying and prioritizing patients who may benefit from care coordination.

This process should consider:

Behavioral health conditions: *May include the following or a combination of the following; diagnosis of behavioral health issue, psychiatric hospitalizations, substance use treatment, positive behavioral health screening (from a standardized tool including substance use).*

High cost/high utilization: *The Department should agree on specific and standardized criteria related to high cost and utilization that may include – potentially preventable ER visits, 30 day hospital readmissions, unusually high numbers of lab tests or diagnostic imaging, unusually high number of prescriptions, high-cost medications, secondary specialist referrals and/or alerts from hospitals indicating high cost or high utilization.*

Poorly controlled or complex conditions: *This may include patients who consistently fail to meet treatment goals or have multiple comorbid conditions (i.e. continued abnormally high hemoglobin A1C, high blood pressure or high cholesterol).*

Social determinants of health: *Processes should be developed to identify patients based on social determinants of health.*

Referrals by outside organizations: *A standardized process should exist by which external entities, practice staff or patients, families and caregivers can request care coordination.*

Cross RCCO evidence-based risk stratification methodology: *This methodology could include a combination of the aforementioned considerations and would be standardized across RCCO's to ensure comparable identification for care coordination.*

Reference:

- *NCQA 2014 4:A "Identify Patients for Care Management"*

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

Monthly core coordination metrics (standard across RCCOs), annual Health Services Advisory Group (HSAG) audits and quarterly RCCO meetings to ensure alignment of care coordination population management efforts.

12) What services should be coordinated and are there services that should not be a part of care coordination?

All services in the patients care should be coordinated and integrated to best meet the individual needs of the patient and family.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

Core Coordination Data: *In order to effectively identify patients who may benefit from core coordination a practice must have information related to behavioral health conditions, hospital and specialist reports, lab data and pharmacy information.*

Health Assessment: *A comprehensive health assessment is necessary to understand the unique needs of patients and their families. Individuals providing core coordination should complete comprehensive health assessments including information regarding: characteristics of family/social structure and culture, communication needs, medical history, advanced directives, behaviors affecting health, mental health and substance use. Developmental screening, depression screening and assessments of health literacy would also provide useful information to assist in care coordination.*

Reference:

- *NCQA 2014 3:C "Comprehensive Health Assessment" & NCQA 2014 4:A "Identify Patients for Care Management"*

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

Today there are multiple care coordination models occurring across the State and RCCO communities. The Solid Care Management Program is committed to improving health and reducing healthcare costs by offering comprehensive, individualized Care Management that empowers high-risk patients with the ability to make healthy choices, improve health outcomes and enhance the client experience. The Solid Care Management team insures that care is coordinated to address the medical, dental, behavioral and social needs of all patients.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

Many non-PCMP providers offer care coordination that may differ from RCCO or ACC care coordination; a primary difference is that outside care coordination is not driven by RCCO or ACC key performance indicators (KPI) or incentives.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

Reducing fragmentation is essential to effective care coordination across the medical neighborhood. The ACC could avoid duplication and disruption of current care coordination relationships through:

***Facilitation of collaboration and accountability** – All members of the medical neighborhood including but not limited to; PCMPs, hospitals, specialists and community agencies must collaborate and determine who will assume overall responsibility for organizing care.*

***Member support** – Patients and families must have access to dedicated staff that can assist in answering questions, minimize confusion and address the logistical challenges of care coordination. If support is telephonic, wait times should be minimal (≤1 minute).*

***Relationships and agreements** – All organizations involved in care coordination must agree on the purpose of care coordination and the role each will play in providing care. Relationships should be identified and standardized agreements should be developed to promote seamless communication.*

***Connectivity** – A cross RCCO information transfer system should be created to allow care coordinators to securely transfer electronic information across RCCOs.*

Reference:

- *Reducing Care Fragmentation: A Toolkit for Coordinating Care. (Prepared by Group Health's MacColl Institute for Healthcare Innovation, supported by The Commonwealth Fund), April 2011.*

d. What are the gaps in care coordination across the continuum of care?

Gaps in care coordination may include but are not limited to:

- *Standardized real-time hospital admission and emergency department notifications*
- *Standardized cross disciplinary information sharing platform*

- *Effective and accessible health infarmotion exchonge*
- *Hospital olignment with KPIs reloted ta hospitol odmissians ond emergency department use*

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☒	
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	
Daycare / childcare	☒	☐	☒	
Economic stability & employment	☒	☐	☒	
Education	☒	☐	☒	
Environment	☒	☐	☒	
Food access / nutrition	☐	☐	☒	
Health literacy	☒	☐	☒	
Housing	☒	☐	☒	
Language or translation services	☒	☐	☒	
Literacy	☒	☐	☒	
Transportation	☒	☐	☒	*The Non-Emergent Medical Transportotian (NEMT) Medicaid benefit is not odequotely meeting tronspartotion needs ond steps*

			should be taken to address this problem at a RCCO and Department level.

Other

Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.

RCCOs should have a role AND coordinate with community supports and services in all above listed categories. The most important role for the RCCO should be to work on the social determinants of health, the RCCOs should coordinate services that fall outside of primary care services.

16) **Requirements about who should be doing care coordination**. Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	Coordinate care? No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	
Certified Addiction Councilors	☒	☐	
Certified Nurse Midwives	☒	☐	
Community Health Workers	☒	☐	
Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☒	☐	
Licensed Mental Health Counselors	☒	☐	
Licensed Professional Counselor	☒	☐	
Masters of Public Health	☒	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	

Nurse Practitioners	☒	☐	
Patient Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☒	☐	
Psychiatrists	☒	☐	
Psychologists	☒	☐	
Registered Nurses	☒	☐	
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	
Other	Please type your response here. *Everyone who has contact with a patient should be at least partly responsible for care coordination.*		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	

Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment: *High Risk populations have unique needs that may require specific care coordination; low risk populations have general needs that may not require care coordination.*			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

RCCOs should place an emphasis on vulnerable populations. Agencies that deliver care to medically or socially underserved children should be actively involved in RCCO care coordination.

19) How should care coordination be evaluated? How should its outcomes be measured?

The purpose of assessing care coordination activities should be clear to drive decisions about measure selection, data collection and reporting. Care coordination should be evaluated using standardized measures that are consistent across RCCOs. Metrics should be designed using nationally recognized care coordination measures (i.e. AHRQ, NCQA, NQF etc.)

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

The cost for providing care coordination services will vary depending on the level of staff rendering care coordination services and the total population. For example, if a health coach provides care coordination the expense will differ significantly from a mid-level medical provider. Appropriate PMPM costs will depend on the total population of patients attributed to a practice. There should be a cap on RCCO administrative costs and/or a required medical loss ratio and RCCO financial performance of should be transparent.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

Higher risk and more complex populations should have a higher associated PMPM.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

No

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

Core coordination should be evaluated using standardized measures that are consistent across RCCOs. Metrics should be designed using nationally recognized care coordination measures (i.e. AHRQ, NCQA, NQF etc.).

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

CHCs should have a role in governance in all RCCOs due to the volume of patients we serve in each region. RCCOs should provide PCMPs with standardized real-time hospital data to promote responsive PCMP care coordination and transitions. The RCCO governance structure should be uniform and ACC program implementation (i.e. Medicaid-Medicare Program, Enhanced PCMP payments, RCCO referral protocols etc.) should be standardized across all RCCOs.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

RCCOs should complete community needs assessments to identify the unique strengths and needs of each community and be held accountable to act upon the findings of these assessments.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

We agree. Practices know how their patients use the healthcare system and they should decide which RCCO to belong to. CHCs that have patients in more than one RCCO region should be allowed to choose which RCCO they can enroll their patients in. This would assure a standardization of care within the CHC delivery model.

27) Should the RCCO region maps change? Why or why not? If so, how?

RCCOs should reflect natural referral patterns and clinical appropriateness, not administrative simplification. If counties have overlap between providers, hospital systems and referral patterns they should not be divided.

28) Should the BHO region maps change? Why or why not? If so, how?

BHO regions should reflect referral patterns and clinical appropriateness, not administrative simplification. At times, BHO separation is a barrier to care, especially with clients living on regional borders; any regional separation should be based an increasing access to behavioral health.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

If the new vendor needs a significant transition period they should not be awarded a contract.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

CHC's play a vital role in Medicaid and in the ACC serve as the PCMP for nearly one-half of all attributed ACC enrollees; up to 72% of the individuals expected to gain Medicaid coverage in 2014 are current CHC

potients. As o key player in the ACC, we support ony legislotion, policy, rule or procedure thot supports: maintoining services ond resources currently provided by CHC's, effarts ta increose occess to comprehensive primary heolthcore for oll Colorodons, increasing funding necessory to expond occess ta heolth core and impravements to Medicoid enrollment, eligibility ond delivery systems.

31) What are the limitatians af the current benefit structure and what – if any – changes are needed?

The Medicoid medical subspeciolty network does not odequately meet the needs af the grawing Medicoid populotion. Accessing behavioral health care services in the Medicoid network continues ta be o challenge and treatment far substonce use ond chronic pain is limited ta non-existent. Dentol services are avoiloble but hove limitations specificolly omong the adult populotian and non-medical resources like housing ond transpartotion.

32) Should there be multiple RCCOs per region? This would invalve twa or mare entities operating in the same region and competing for clients and praviders. If so, why? If so, how many and where? What issues would this address?

Na

Subsets of ACOs shauld be ollowed within eoch RCCO region. CHCs due ta their volume of Medicaid potients should be ollowed to be their own ACO within o RCCO region. Current doto demonstrotes that CHCs ore more cast effective ond should be oworded through shared sovings models far their perfarmance.

33) If you ar yaur practice pravide services to clients referred through a BHO, but you are not a Medicaid pravider, would you be willing ta become a Medicaid provider? If so, what has prevented you fram becoming a pravider in the past? If nat, why not?

N/A

34) What role should RCCOs play in attributing clients to their respective PCMPs?

Stondords should be established for ottributian. RCCOs should be ollowed a minimum af 3 months to ottribute o potient. Once ottribution is determined, the core manogement dollors for the 3 months the potient wos not attributed should flow to the entity praviding core monagement services to these potients.

RCCOs should use their level af dato access to pravide onolytics ta assist PCMPs in the ottribution process obove ond beyond the monthly cloims-bosed attribution process. Data onolytics ond ottribution strotegies should be stondardized ocrass RCCOs to oid providers in multiple ACC regions.

RCCO's should prioritize ottributian ta high performing PCMPs who ore open to new Medicoid patients, have o core delegation ogreement in ploce, meet notionolly recagnized occreditotion standords ond meet o minimum threshold af Medicoid clients ar o percent of the overoll overoge.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

The ACC Program and the Colorado Department of Public Health and Environment should work together to pursue local partnerships with public health departments, and collaborate on programs related to prevention, health disparities, health care access and other opportunities concerning population health.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

No comment

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

Improvements are still needed to ensure correct and timely attribution. The ACC Program should work with the insurance marketplace/Connect for Health Colorado and PEAK to help develop a method to allow patients to choose a PCMP when enrolling in Medicaid.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

No comment

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

RCCOs should be required to engage stakeholders via public forums, sotisfactian surveys ond telephanic customer service assistance that is reodily available to ACC members with minimol woit times (≤1 minute).

40) What specific requirements should RCCOs have for stakeholder engagement with praviders, community organizations, social service providers, and athers in their region?

RCCOs should reach aut to oll community stakehalders in the regian ond estoblish ongaing cammunication with cammunity leaders in an effort to maintain bidirectianal cammunicatian and increase continuity of core across the medical neighborhaad.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

See obave

42) How should the Department structure stakeholder engagement for the ACC as a whole?

The Department should cantinue engaging stokeholders as per previaus ACC octivity and create a telephanic customer service line that is readily avoilable to ACC members with minimol woit times (≤1 minute).

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

No

a. If no, what are the gaps?

The Medicaid medicol subspecialty network does not odequately meet the needs of the growing Medicaid populotion. Accessing behoviorol heolth core services in the Medicoid network continues to be o chollenge ond treatment for substance use and chronic poin is limited to non-existent. Dentol services ore ovoiloble but have limitations specifically among odults; ond o lack of non-medicol resources like housing ond transportation continue to present chollenges to the Medicoid populotion.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

There ore gops in services for both children and odults with cognitive disobilities, develapmental delays ond the outism spectrum diognoses. Theses subpopulations need more occess to resources for assessment and treotment. Primory care can ond should still be the medical home for these clients with odditional options for externol referral's and speciolized core.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

Hospitol systems must be octive participonts in the ACC Progrom. Without hospitol involvement ond reol-time doto sharing we will see minimol success in previous and current ACC KPIs. Hospitals should be incentivized for reducing re-hospitolizotions ond they should be penolized for inopprapriote ER visits.

b. What role should pharmacies play in the next iteration of the ACC Program?

Phormocies con help olert providers when potients are prescribed brond-nome drugs instead of generic olternotives and ossist with communication around medicotion informotion. The ACC should support phormocy integration in primary care offices, including on-site clinicol pharmacists; this intervention hos been proven to increase heolth outcomes omong the Medicoid populotion.

c. What role should specialists play in the next iteration of the ACC Program?

The Medicoid subspeciolty network does not odequotely meet the needs of the growing Medicoid populotion. Before we identify what role speciolist will ploy in the ACC progrom, we must oddress the deficient subspeciolty network.

d. What role should home health play in the next iteration of the ACC Program?

The ACC should continue to support home health as an essential service available to Medicaid recipients.

e. What role should hospice care play in the next iteration of the ACC Program?

The ACC should continue to support hospice care as an essential service available to Medicaid recipients.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

Resources for CCBs should be expanded to provide better care to patients with cognitive disabilities, developmental delays and the autism spectrum diagnosis without the patient needing to be on a waitlist that can be up to 8 – 12 years.

g. What role should counties play in the next iteration of the ACC Program?

County offices play an important role in helping Medicaid recipient's access benefits and resources; yet communication often breaks down between counties and the ACC program. Counties should be key participants in the ACC program to ensure clients access county services in a meaningful and efficient manner. RCCOs should partner with county offices to ensure access is coordinated and integrated to best meet the individual needs of the patient and family.

h. What role should local public health agencies play in the next iteration of the ACC Program?

Local public health agencies should collaborate with RCCOs and PCMPs on programs related to prevention, health disparities, health care access and other opportunities concerning population health.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

Community organizations and non-profits are critical members of the medical neighborhood and should be included in the next iteration of the ACC.

45) How can RCCOs help to support clients and families in making and keeping appointments?

Transportation is often a barrier that prevents clients and families from making and keeping appointments. The Department must address deficiencies with the NEMT Medicaid benefit and RCCOs could play an important role in holding NEMT accountable and ensuring regional transportation is efficiently functioning to meet the needs of ACC members.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

The Department should require anything that the evidence has shown to be effective, and they should encourage innovation where there is no evidence.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☒
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☒

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

RCCOs should promote access to PCMPs who offer co-located dental care to children and adult ACC clients and ensure access to adult, pediatric and specialty dentistry to all ACC members.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

According to the National Institute of Health, the concept of cultural competency has a positive effect on patient care delivery by enabling providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients. Among many other things this may include the ability to provide services across the entire patient experience in the patient's primary language and limit the use of interpretation services.

Reference:

- *National Institute of Health "Cultural Competency"*

b. What RCCO requirements would ensure cultural competency?

RCCOs should promote and offer standardized cross regional training on cultural awareness and sensitivity. RCCOs should require that all PCMPs follow NCQA PCMH standards around culturally and linguistically appropriate services. In the event that any provider or resource does not offer culturally

ond linguisticolly oppropriote core the RCCO should provide ot minimum, foce-to-foce interpretotion services to meet the member's longuoge needs.

Reference:

- *NCQA 2014 2:C "Culturolly ond Linguisticolly Appropriote Services"*

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

Providers ond stoff must hove the obility to ossess the diversity ond longuoge needs of its populotion, provide interpretotion or bilinguol services to meet the longuoge needs of its populotion ond provide printed moteriols to clients in their preferred longuoge.

Reference:

- *NCQA 2014 2:C "Culturolly ond Linguisticolly Appropriote Services"*

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

RCCOs should promote troining on effective communicotion with oll segments of the potient populotion, but porticulorly vulneroble populotions; troining moy include heolth literocy or other opprooches to oddressing communicotion needs. Additionolly, RCCOs should require PCMPs ossess heolth literocy to ensure the potient, fomily, or coregiver understond the concepts ond core requirements ossocioted with monoging their heolth. Finolly, when necessory, RCCOs should require PCMPs provide the potient, fomily or core giver core plons thot ore toilored to occount for heolth literocy ond longuoge considerotions.

Reference:

- *NCQA 2014 4:B5 "Core plon is provided in writing to the potient/fomily/coregiver"*
- *NCQA 2014 2:C "Culturolly ond Linguisticolly Appropriote Services"*
- *NCQA 2014 2:D7 "Troining ond ossigning members of the core teom to monoge the potient populotion."*

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

Only if this increoses occess to speciolty, focility or oncillory core without increosing cost.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

The ACC must support policy chonges thot disincentive hospitols from providing emergency services for non-emergent conditions ond incentivize PCMPs for increosing occess. RCCOs should incentivize providers who meet notionolly occredited occess stondords ond provide urgent core ond routine visits on the some doy they ore requested ond outside regulor business hours. Lorge hospitol systems thot see Medicoid

recipients should be actively involved in ACC PIAC ond subcommittee work araund inappropriote utilizotian of the hospitol and effective care coardinotion across the medicol neighbarhoad.

Reference:

- *NCQA 2014 1:A "Patient-Centered Appointment Access"*

52) Please feel welcame to share ather general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☒	☐	☐	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☒	☐	☐	☐
Provide registries	☒	☐	☐	☐
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☒	☐	☐	☐
Supply behavioral health surveys	☒	☐	☐	☐
Supply other self-screening tools	☒	☐	☐	☐
Administer behavioral health surveys	☒	☐	☐	☐
Administer other self-screening tools	☒	☐	☐	☐
Prepare client action plans	☒	☐	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☒	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☒	☐	☐	☐
Provide standing pharmacy order templates	☒	☐	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☐
Provide directory of other resources	☒	☐	☐	☐
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐

Others	*Proctices thot connot perform these functions should not be considered PCMP's in the ACC.*

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

N/A

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

Doto onolysis ond reol-time hospitol notificotions for hospitol follow-up ond cooching oround the pursuit of notionolly recognized medicol home stondords ond guidelines.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

Provide enhonced poyment to PCMPs who meet notionolly recognized medicol home criterio.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

Yes

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

PCMPs responsible for care improvement and cost savings should be rewarded with shared savings and incentive payments and the ACC should continue to move away from fee for service (FFS) towards population-based payment with a path towards taking on risk over time. Incentives should be aligned with outcomes, real KPI performance and best practices.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

Yes

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Yes, but continued efforts must be invested in providing PCMPs with more complete patient care and cost data. Data must be real-time in order to provide meaningful coordination of care.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

No comment

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

RCCOs should not have a role in the distribution of payments to providers.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

We support payment reform measures and get away from FFS. Any payment reform would have to protect the CHCs FQHC payment methodology. We do support payment for direct services going through the RCCO. Furthermore, the financial performance of the RCCOs and BHOs should be transparent and limit administrative costs.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

A required medical loss standard should be established to limit administrative costs and profits at the RCCO level. Nationally recognized quality measures based on health outcomes and evidence-based best practices should be used for the ACC and dollars should flow to the entities providing the direct services.

However, this is o major question thot wauld require significont conversation ond negotiotion with pragram participonts.

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	
SF-12 Health Survey	☐	☒	
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☐	☒	
Focus groups	☒	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

It should be meosured using notionolly recognized quolity meosures proven to decreose cost ond improve heolth outcomes.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

Quolity ond performonce doto should be tronsporent ollowing RCCOs ond PCMPs to leorn from one onother ond shore best proctices in on effort to collectively improve potient outcomes, increose potient sotisfoction ond positively impoct totol cost of core.

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☒
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐

None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☒
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Yes

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Both. RCCOs should be reimbursed bosed on improvement until notionol stondords ore reoched, then reimbursement should be tied to future stondords, then stoy the some. Once you hit o certoin level of performonce you con't improve ony more, but you should not lose your reimbursement incentive.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

No

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

Fixed cost (administrative) should be limited to 10 – 15%.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Solud's Quality Impravement Program is dedicoted to ongoing excellence in the quality ond sofety of core ond services delivered. We measure quality in oll facets of the organization including clinicol, monagerial, odministrotive ond facilities. Quolity meosures are bosed on notionol standords including: Bureou of Primory Heolth Care, Federol Tort Cloims Act, Health Resources and Service Administrotion, Meaningful Use criterio, NCQA, PCMH ond U.S. Preventive Services Tosk Force.

Exomples of current quolity improvement projects include but ore not limited to: cancer screening, chronic disease monogement, tobacco screening, medicotion monogement, well child checks, depression screening and pediotric/odolescent weight monagement.

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☒	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☒	☐
Practice assessment tools	☒	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☒	☐
Shared decision-making tools	☐	☒
Telemedicine software	☒	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the 5DAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☐	☐	☒
Health risk assessment software	☐	☐	☐	☐	☒
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☒
Patient education wellness tools	☐	☐	☐	☐	☒
Provider/case manager directory	☐	☐	☐	☐	☒
Shared decision-making tools	☐	☐	☐	☐	☒
Telemedicine	☐	☐	☐	☐	☒
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Borriers include bondwidth limitotions, difficulty integroting HIT with EHRs, inodequote IT infrostructure, inobility to bill for HIT services, minimol resources ovoiloble to troubleshoot ond ossist consumers of HIT ond high monthly costs of HIT solutions.

81) How can Health Information Technology support Behavioral Health Integration?

HIT con be used for behoviorol heolth integrotion through integroted EHR documentotion, potient portol occess ond communicotion, heolth informotion exchonge, populotion onolytics ond tele-heolth.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

Yes. An onolytics plotform should contoin KPI doto, stondordized core coordinotion risk strotificotion criterio ond informotion on specific quolity meosures.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

No

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

Yes. Criterio could include: KPI doto, stondordized core coordinotion risk strotificotion criterio ond informotion on specific quolity meosures.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

Avoiloble online ond in poper form in multiple longuoges; online version should contoin seorchoble fields reloted to provider/speciolty type, locotion ond if the provider is occepting new Medicoid clients.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

RCCOs should work with hospitols to provide PCMPs with stondordized reol-time hospitol doto ovoiloble from o centrolized source os opposed to multiple doto sources.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

RCCOs should work with hospitols to provide PCMPs with stondordized reol-time hospitol doto. This doto should be mode ovoiloble from o centrolized source to ovoid frogmentotion of hospitol doto. Heolth informotion exchonges could serve os plotforms to distribute this doto however the technology needs to be improved to ossure PCMPs ore receiving reol-time doto from oll hospitols for every potient.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

RCCOs should work with hospitols to provide PCMPs with stondordized reol-time hospitol doto ovoiloble from o centrolized source os opposed to multiple doto sources.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

Heolth informotion exchonges could ploy on importont role in the next iterotion of the ACC, however they must moke technicol improvements to enoble system integrotion with EHRs, the obility to olert providers when potients orrive ot o hospitol focility ond they must not be o finonciol burden for PCMPs.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 092

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Elaina Hockaday, Barbara Selter
Location: Denver, Denver, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: MAXIMUS
Location: Denver, Denver, Colorado
X Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
X Other (please describe): Enrollment Broker, Ombudsman for Colorado Medicaid

Are you currently involved in the ACC program?
X Yes as an administrative support organization to HCPF
☐ No

If you answered "yes" above, how long?
X Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
As the Enrollment Broker and Ombudsman for HCPF, MAXIMUS enrolls the clients into the RCCOS; As the Ombudsman, we field consumer calls and assist with problems.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
MAXIMUS is the Enrollment Broker and Ombudsman in Colorado and 17 other states and the District of Columbia. We administer the CHIP program in eight states, and support State-Based Exchange operations in six States.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?
☐ Very likely
☐ Likely
X Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Should the State decide to separate administrative functions from clinical care coordination functions, MAXIMUS would consider bidding on any administrative functions that may be in our area of expertise.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

The core premise of the Accountable Care Collaborative is local control and delivery of medical and non-medical services, and this remains the most compelling feature of the ACC. The creation of sustainable medical homes through which clients receive the full range of care from coordinated and commonly incented providers is the clear strength of the program to improve the quality and client satisfaction with the care delivered. Early returns on cost improvements through this delivery model of $100 million in gross, and $30 million in net savings are testament to the ACC model. While savings have been impressive, improvements in reducing ER visits, high-cost imaging services and 30-day all cause readmissions demonstrate the efficacy of coordinated care delivery through a medical home model.

2) What is not working well in the ACC Program?

The Regional Care Collaborative Organizations (RCCO) are vested with the responsibilities of ensuring a medical home level of care for every member; developing, managing and supporting a high-quality provider network; delivering medical management and care coordination across the provider teams; and overall program accountability and reporting. With only 69% of the 720,000 members attributed to a medical home, we believe this is an area for improvement. Specifically, the HealthColorado staff could be performing primary care medical provider (PCMP) attributions as an extension of the current enrollment broker function. In other states where MAXIMUS functions as the enrollment broker we play a vital role in providing unbiased choice counseling to help clients identify the PCMP best suited to meet their individual needs at the time of enrollment into the Medicaid plan. In many cases, MAXIMUS achieves attribution in excess of 90%.

This is but one example of the improvement opportunity available to the ACC model: the unification and centralization of certain administrative functions in support of all the RCCOs. Eliminating the duplicative and redundant processes (and the costs) across the RCCOs will enable them to focus their efforts on provider network development, management, and support of local care coordination and delivery.

Through our work as the Enrollment Broker and Ombudsman in Colorado, we have had an opportunity to speak with Medicaid clients receiving services through the ACC structure. From these stakeholder conversations, we have been privy to information about the challenges presented by the ACC organizational structure from both the recipient and provider perspectives:

- **From the perspective of recipients:** Network adequacy is a problem, especially in the behavioral health system. The ability to seek treatment from a provider of choice, who may or may not be in the client's selected RCCO leads to confusion and at times, limitation on the individual's ability to be seen by a given provider, who may be reluctant to take on a patient outside the RCCO of the provider's affiliation.

- **From the provider's perspective:** The ability of a client to see any provider regardless of their RCCO affiliation also is problematic. Many providers are unhappy with the RCCO policy that permits Medicaid clients to see any provider, whether or not they are enrolled in a RCCO different from the one with which the provider is registered. In this situation, PCMPs may be providing service to patients outside their designated RCCO. Because there are not standardized rules across the various RCCOs, providers who see patients outside their enrolled RCCO may lose the "shared savings" associated with high performance, and therefore be penalized financially for seeing the client. As the rules vary across RCCOs, it becomes problematic for the providers who could potentially be penalized for serving certain patients, while the patient may realize difficulties in receiving services from a desired provider.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

The Enrollment Broker can play an important role in the initial enrollment of individuals into coordinated care. Currently, we perform an "Expedited Screen," which is a very limited health risk assessment performed when the Medicaid client is selecting a RCCO; this tool could be expanded to include various behavioral health needs indicators.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

"Care coordination delivers health benefits to those with multiple needs, while improving their experience of the care system and driving down overall health care (and societal) costs" is the definition posited by Craig, Eby and Whittington from their 2011 Institute for Healthcare Improvement white paper Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs. MAXIMUS subscribes to this definition in the development of operating and service delivery models in support of our state clients precisely because it recognizes the Gordian knot of social determinants to health and health outcomes that typifies the population served by Medicaid. Through the use of this definition, the opportunities apparent in separating the concerns of the RCCO medical delivery role and the potential expanded role of the HealthColorado capabilities to marshal a state-wide care coordination capability to the RCCO are revealed.

b. How should RCCOs prioritize who receives care coordination first?

HealthColorado has the perfect opportunity when enrolling clients to perform a health risk assessment, which could be forwarded directly to the RCCO. This assessment would capture both medical and social determinants to ascribe initial triage and actions through the ACC. By having this data upon initial enrollment of the individual, the RCCO could identify those who need care coordination earlier than if the RCCO had to wait until the individual made an initial appointment with the provider.

c. How should RCCOs identify clients and families who need care coordination?

HealthColorado currently completes an expedited appointment screen for those who call to enroll. This screening could be modified to be more useful in identifying clients and families who need care coordination. HealthColorado could collect and send this enhanced assessment data to the RCCOs that in turn could utilize this information for managing their population.

The use of "up front" health assessments and health risk assessment data analysis, performed by the data analytics contractor, would likely result in more quickly identifying those who are in most need of care coordination. Those Medicaid clients with co-morbidities, chronic conditions, or behavioral health issues would be most likely to benefit from care coordination.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

Managing the beneficiary's relationship to the Medicaid program across the RCCO entities is fundamental to having an expanded role of a central coordinating entity. The concept of active

relationship management, one which understands where the individual falls across the continuum of coverage and benefits delivery is critical to maintaining high degrees of client satisfaction, utilization management, and cost control. MAXIMUS has coined the phrase Citizen Journey™ to capture this active management concept. Leveraging existing technologies – the Health Information Exchange, the electronic health records of providers, and the core Medicaid systems environment – the ability to track and manage a beneficiary's journey through the delivery of care across the continuum of delivery networks is achievable. At a very high level, the initial capture of the individual care plan, the distillation of the care plan into discrete, forecasted and time-bound 'events', and the message-based tracking of the plan over the course of the treatment episodes is the basis for achieving active management. Centralizing this capability at HealthColorado rather than devolving it to the RCCO and attempting to recompile each action across the RCCO at the SDAC, represents a more efficient and cost effective means for the State to achieve this fundamental need.

12) What services should be coordinated and are there services that should not be a part of care coordination?

Some care coordination activities are performed most effectively in a localized environment. However, there are some care coordination functions that could be cost-effectively delivered through a clearinghouse environment. For example, outbound reminder calls is a capability best suited for a statewide clearinghouse environment. Using this approach for diabetics, as an example, multiple small providers could provide a file of diabetic patients who are overdue for Hemoglobin A1c testing. MAXIMUS contact center agents could provide an outbound calling campaign centrally to remind patients from many different providers (and different RCCOs around the state) to schedule such testing with their PCMP. Many providers do not have the resources to perform this outbound calling cost efficiently within their own practices. Again, this is something that could be centralized, so that existing telephony and staffing capacity could be shared among multiple providers for these outbound care reminders.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

HealthColorado could assess urgent needs immediately with a new client during that first phone call, asking questions not only of medical needs such as what prescriptions someone is using and whether they are going to need a refill before their first appointment with the PCMP; but also to check with new clients on their social needs such as whether they need urgent help with housing or food. It may be best to start with a simple question: "What would be the most helpful thing for a case manager or RCCO to help you with today?" Addressing the individual's most urgent needs is critical; if they are homeless and hungry, a care coordinator or social worker needs to help with that first. There are categories of care and clinical indicators such as diabetes, COPD, short or long-term disabilities, and so forth– to which best practices protocols can be established and proactively trigger action based on the diagnosis.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	X	☐	X	
Affordability (assistance with prescriptions or co-pays)	X	☐	X	
Daycare / childcare	X	☐	X	
Economic stability & employment	X	☐	X	
Education	X	☐	X	
Environment	X	☐	X	
Food access / nutrition	X	☐	X	
Health literacy		X	X	This is something that could be done centrally by the MAXIMUS Center for Health Literacy that could provide materials to all of the RCCOs operating across the State
Housing	X	☐	X	

Language or translation services		X	X	The MAXIMUS Center for Health Literacy could use its Translations Group to provide adaptive translations for all RCCOs centrally
Literacy	☐	X	X	The MAXIMUS Center for Health Literacy could provide literacy services for all RCCOs centrally
Transportation	X	☐	X	
Other	To the extent that any administrative functions, such as maintenance of statewide databases of community supports and services, can be facilitated through centralized processing, we believe that can result in greater efficiencies for the ACC.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	X	☐	A coordinated, multi-disciplinary team to perform care coordination is most likely to be effective. Most importantly, to obtain the greatest value for the health care dollar, we recommend use of the "right" resources for the needed level of care coordination. This might mean use of non-clinically trained staff for certain functions such as follow up, health education, and other non-clinical functions with planning and oversight being provided by staff with more clinical training.
Certified Addiction Councilors	X	☐	
Certified Nurse Midwives	X	☐	
Community Health Workers	X	☐	
Generalists (BA/BS/MA/MS)	X	☐	
Health Coaches	X	☐	
Licensed Clinical Social Workers	X	☐	
Licensed Marriage and Family Therapist	X	☐	

Licensed Mental Health Counselors	X	☐	
Licensed Professional Counselor	X	☐	
Masters of Public Health	X	☐	
Medical Doctors / Doctors of Osteopathic Medicine	X	☐	
Nurse Practitioners	X	☐	
Patient Navigators	X	☐	
Peer Advocates	X	☐	
Promotoras	X	☐	
Psychiatrists	X	☐	
Psychologists	X	☐	
Registered Nurses	X	☐	
Social Workers	X	☐	
Wraparound facilitators	X	☐	
Other	We recommend the use of non-clinical call center staff to do centralized appointment scheduling for different members of the care coordination team. These call center staff can also provide cost effective outbound reminders for overdue tests, vaccines, or medication management.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	

Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	X	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	X	☐	Outbound reminders for this and the following checked groups could be a cost effective mechanism for reaching this population in a home and community-based environment.
Clients in a nursing facility		☐	
Elderly clients	X	☐	
Frail elderly clients	X	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

For all intents, the underlying driver of the cost is the level of services offered, which to the second question, does vary by population served. In this way, the State may wish to consider a 'core' administrative PMPM for the category of 'care coordination services' and a population/needs-based 'rate card' PMPM approach for specific populations.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population? No, in practice MAXIMUS has seen States achieve improved management of service outcomes through their contractors by requesting the client ratios they intend to establish, and their rational for the ratios. This enables the State to solicit the best offer based not on an external variable that may (or may not) comport to a contractor's business model, but based solely on the expertise and understanding of the contractors offers. We do believe that establishing reasonable metrics for delivery against these ratios, however, do become a negotiated item at contracting to ensure the State is receiving the value for which it bargained.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

From our research and work in formulating telecare and telemedicine strategies, we believe there is a great potential to combine remote monitoring technologies with call center capacity to provide low cost reminder interventions that can identify needs for actions without involving more costly personnel. Using an Independence Coach to set up the system and teach the elderly or those with disabilities living in the community to use a platform that include vital sign monitoring, remote monitoring sensors, and video conferencing, we can expand the number of clients receiving care coordination through use of virtual visits. Call center agents can be trained to follow physician developed protocols, which indicate when vital sign collection devices and remote monitors are showing values outside of established norms. These call center agents could then take designated follow-up actions with Medical Home Case Managers, RCCO Care Coordinators, family caregivers, or other designated parties. This approach allows the Medicaid program

and the RCCOs to better target their care coordination resources where and when they are most needed. The technical platform could also be used to provide chronic disease management health education to Medicaid clients and/or their family caregivers, enhancing the experience for all participants in the RCCO healthcare delivery system.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

From the input we have received from our Medicaid clients, MAXIMUS believes that all of the functions mentioned above - care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies, as well as attribution efforts should be standardized. By centralizing a range of administrative functions, the RCCOs could achieve their real purpose: – providing clinical case coordination that achieves better care outcomes. Now there are different performance metrics, quality indicators, and payments for each RCCO, so providers are penalized for seeing patients outside their established RCCO relationships. The providers would benefit from standardizing the contracts across RCCOs, because by standardizing the process for earning and paying incentive payments across all RCCOs, providers can be appropriately compensated for the services they are actually providing to patients. Therefore, we recommend that contracts be standardized, enabling requirements to be similar across RCCOs. Administrative functions that could be centralized include:

- **Provider Attribution:** The process for attributing patients to PMCPs is currently performed by individual RCCOS, and it is time consuming for these entities to perform this function. By incorporating this function as part of the Enrollment Broker services, a centralized call center can provide this capability when the client is first contacted with information about enrolling in the ACC infrastructure.
- **Provider Support Services:** Currently, there is some reluctance of providers to participate in the RCCOs because of the differences in "shared savings" arrangements and having to include treatment of patients outside their own RCCO. Providers are concerned about the impact of these patients on the "shared savings" model. Additionally, providers have issues with not being able to "open and close" their panels as they see fit. To address some of the providers' concerns and encourage provider participation in the RCCOS, the State could provide a centralized set of administrative services for all providers regardless of their RCCO affiliation, including credentialing, education, outreach, payment processing, and a provider service center that offers providers a single number to call to get information about and from the program. This approach would make participation in RCCOs and receipt of payment easier, encouraging providers to participate in the ACC structure.
- **Scheduling:** By centralizing the scheduling of in-home assessments for dual eligibles, the State can achieve more efficient utilization of staff resources, as well as better coordination of field-based assessment staff located across the state. In our projects in Pennsylvania and New York, where we perform in-home functional assessments for clients needing Long Term Services and Supports, we have used geo-mapping capabilities to achieve more efficient utilization of our assessment staff, moving from being able to administer one to performing two or more assessments per day by just enhancing our scheduling software. We can also centrally schedule provider appointments and make outbound reminder calls to discourage "no shows". This will improve the utilization of limited providers, particularly in rural areas with a limited supply of behavioral health clinicians.

- **Outbound Calling and Reminders:** A centralized call center can provide convenient, cost effective outbound calling and reminders to patients who may go to multiple providers or to providers in different RCCOs. By providing this as a centralized service, smaller practices without the staff to perform these functions can realize the benefits of such outbound reminders, education calls, and alerts with little economic impact.
- **Payment Processing:** By creating a centralized payment structure, it would be easier to pay providers for seeing patients outside of the RCCO with which the provider is affiliated. This would allow providers to gain shared savings based on the same quality metrics and incentive payments, regardless of with which RCCO they or their patients are affiliated.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

RCCOs must recruit staff that has connections in the local community. Depending upon the nature of the community, the RCCO should have staffs that speak the languages that Limited English Proficiency (LEP) clients speak in a given community. RCCOS should develop culturally and linguistically appropriate materials that are easy to understand and can be read by those with low literacy levels. RCCOs should demonstrate they have meaningful and formal partnerships with community support organizations, particularly for long-term care support services and for clients who have special health care and social support needs. They should demonstrate via contracts and reimbursements that they truly value the role of the organizations and include them as part of the care provided to clients, many of whom have depended highly on these organizations prior to their acquiring Medicaid.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This approach could cause complexity for the state systems, especially in the areas of attribution and passive enrollment. This approach would also make it much harder for specific RCCOs to serve their clients. For example, if a client lives in Jefferson County, but that client is in RCCO 2, RCCO 2 would have a much harder time helping the client with all other services. If such an arrangement were to be put in place, each RCCO would have to maintain state-wide relationships and provide referrals rather than being able to focus on their particular region. Therefore, we recommend having a standardization of contracting arrangements for all RCCOs. Our preferred approach is to maintain the localized care management concept, which is one of the strengths we see in the RCCO concept.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

Should the State determine that they want to centralize some of the suggested functions, the transition to new vendors would take a shorter time, as these administrative functions could be put in place once, leveraging an existing facility in Denver, rather than having to implement them in each RCCO region. This approach could save both time and money for the State.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

By standardizing contractual requirements and shared savings payment structures for all RCCOs, the State could avoid many of the provider concerns around treating patients belonging to a different RCCO, so that the shared savings could be calculated based upon the patient panel, rather than by RCCO, allowing providers to receive credit for good outcomes on patients belonging to different RCCOs. This will encourage more providers to participate, and reduce the shortage of providers in some areas.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

One area in which we would recommend assistance is in lowering co-pays for clients.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

In our experience as an Enrollment Broker in a number of states, many Medicaid clients select managed care organizations based upon the affiliation of their PCMPs rather than the other way around. Therefore, we believe in areas where there are more than one RCCO, should the state move to that model, it would be very important for an unbiased choice counselor to manage the attribution.

Further, by assuming responsibility for the attribution of clients to their respective PCMPs, HealthColorado could improve the efficiency of operations. HealthColorado already captures information about the client and the client's RCCO choice. By sending the information to the RCCO and then having the RCCO reestablish contact with the client, the State is wasting time and money. If the client does not call the call center and make a choice, the HealthColorado staff could easily follow up with the non-callers performing an outbound call. This approach would reduce the time spent by the RCCOs on this administrative function, and allow them more time to provide care coordination and community outreach.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

The ACC Program should be collaborating with the CO Department of Public Health and Environment on "healthy communities" programs. The local nature of the RCCO puts it in the perfect position to work individually with stakeholders in the region to develop health goals for the community. If administrative responsibilities were removed from the RCCOs, these organizations could concentrate more on the most important health goals of the community.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

Again, the RCCOS functioning in a local capacity are well-positioned to coordinate the social services needed to ensure healthy outcomes. The social determinants of health are critical, and by removing administrative functions from the responsibilities of these organizations, perhaps they could concentrate more on working collaboratively with housing, social services, and other resources in the community that directly could have bearing on the well-being of the Medicaid clients in the local community.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

The local nature of the RCCOs put them in the best position to engage with clients, client's families, and client advocates. The coordination of care in a broad sense – through health education, healthy communities projects, and close collaboration among the clients and their advocates—is a critical role for RCCOs to play to achieve the outcomes that the State is seeking. Again, by re-directing administrative functions that can be performed most efficiently in a centralized environment to a statewide entity, RCCOs would more likely have the resources to devote to stakeholder engagement, a more logical function for them to perform.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

Because of the importance of social determinants of health, we strongly recommend that the RCCOs have stringent requirements for stakeholder engagement with providers, community organizations, social service providers, and others in their region. In a project we are planning in rural California, MAXIMUS is testing the concept of Independence Coaches and Community Assistors to help low income, medically underserved seniors remain in their homes. The Independence Coaches are individuals who act as health educators, "problem solvers," and coaches to enable these seniors to receive the services and socialization they need to remain safe and healthy in their homes. When needed, Community Assistors are part time workers who can be dispatched to perform various tasks (such as going to the grocery store, picking up prescriptions, providing rides to the doctor and so on) to assist the senior in the local community. We believe this model of emphasis on both the social and medical aspects of care can result in improved health outcomes, especially in rural areas.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

In many of our projects, MAXIMUS has outreach workers who work collaboratively with community groups to reach "hard to reach" constituents. The RCCOs should employ similar outreach workers who are specifically trained to perform outreach functions in the local communities. We recommend recruiting staff from local areas that have knowledge of the communities in which they will be serving.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Stakeholder engagement should be locally determined. The needs of the individual communities should be driving the goals for "healthy communities" and the best ways of delivering care in these local communities. While administrative functions can be enhanced through economies of scale, stakeholder engagement will flourish if it is closely tied to the culture and needs of the communities the RCCO is serving.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

Telecare and telemedicine are coming to play an increasingly important role in the delivery of health care and the increase of access to care in the rural communities. The State should carefully consider the role of telemedicine in delivering access to specialty care in rural parts of the state.

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

Partnerships with local community groups have always played a major role in MAXIMUS Medicaid projects. We strongly recommend that the RCCOs establish a network of social, community, religious, business and professional, and ethnic organizations with which to work in their local areas. This provides an effective mechanism for reaching "hard to serve" constituencies. These resources should be available through a centralized directory of resources.

45) How can RCCOs help to support clients and families in making and keeping appointments?

MAXIMUS has tested centralized appointment scheduling and outbound reminder calling in several of our projects performing assessments for Long Term Services and Supports. We use a "hub and spoke" model, where the scheduling is centralized and the assessments are performed locally. We have found that there are significant advantages to performing appointment scheduling centrally. By using geo-mapping capabilities, we are better able to select the nearest assessor and reduce the time and cost of travel. Using centralized scheduling, we are also able to perform many more assessments in a single day, reducing the cost of the staffing for performing these assessments. By providing centralized appointment outbound calling, the RCCOs can leverage an existing State resource, providing inexpensive outreach that would be impossible if performed by each provider's office. Using our existing telephony infrastructure, MAXIMUS can create outbound calling routines that provide automated reminders and can significantly reduce no show rates, saving money for providers and increasing the availability of provider hours.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

In several of our projects, MAXIMUS is testing the use of Patient Navigators, especially in the area of assisting persons to select appropriate health insurance plans to meet their individual needs. We have found in–person assistors to be invaluable in helping people to navigate the health care system. We are further working on combining the use of Community Health Workers or Patient Navigators, telecare remote monitoring platforms, and call centers to provide enhanced services to seniors aging in place. We recommend that the State consider the use of these less expensive, but oftentimes highly effective workers to augment the services already being provided by the RCCOs.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	X
On staff (salary) at Primary Care	☐

Medical Provider Clinic	
On staff (salary) at RCCO	X
Per Member Per Month Payment	X

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically responsive care to all Clients/families including those with low health literacy?

Statistics abound showing that low literate and Limited English Proficiency (LEP) clients often have poorer outcomes than their English-speaking counterparts. The MAXIMUS Center for Health Literacy (the Center) was created specifically to deal with the problem of limited health literacy in the Medicaid population. The Center can provide educational materials, translation services, websites, and other communication strategies to help providers communicate with their culturally and linguistically diverse clients. One service that we could provide centrally to all RCCOs is the ability to perform real time translations for individual providers seeing LEP patients. These services could be particularly effective using telemedicine consults where the translators and the providers are simultaneously speaking with the patient.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

The State should require that the RCCOs provide culturally and linguistically appropriate materials, including health education and promotional materials, translation services, and communication strategies that are designed to address the needs of low literate, LEP, and culturally diverse populations.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Pro-active health prevention strategies are key to reducing emergency room usage and hospital re-admissions. MAXIMUS is currently working on a pilot to use remote monitoring technology, call centers, and telehealth home consults to reduce adverse events including emergency room usage, re-hospitalization, and falls in the home. This proactive approach to managing chronic conditions can be effective in reducing emergency room utilization.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

We recommend that the State consider the use of in-home telehealth consults, especially from specialists and behavioral health providers to augment areas where there are limited supplies of certain types of specialties and mental health providers.

Practice Support

53) **Support for practices**. Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	X	☐	☐	X
Network provider education	X	☐	☐	X
Assistance with practice redesign	X	☐	☐	X
Assistance with efficiency-enhancing activities	X	☐	☐	X
Provide web-based resources and directories	X	☐	☐	X
Provide practice-specific data reports	X	☐	☐	X
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	X	☐	☐	X
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	X	☐	☐	X
Offer client reminders	X	☐	☐	X
Offer client self-management tools	X	☐	☐	X
Offer educational materials about specific conditions	X	☐	☐	X
Supply behavioral health surveys	X	☐	☐	X
Supply other self-screening tools	X	☐	☐	X
Administer behavioral health surveys	X	☐	☐	X
Administer other self-screening tools	X	☐	☐	X
Prepare client action plans	X	☐	☐	X
Provide training on providing culturally-competent care	X	☐	☐	X
Provide training to supporting staff	X	☐	☐	X
Provide training on motivational interviewing	X	☐	☐	X
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	X	☐	☐	X
Provide directory of other resources	X	☐	☐	X
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others	Centralized outbound reminder calling			

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

The State should consider the use of centralized data mining and call centers to provide care reminders across multiple practices. While large practices may have the resources to provide such analysis and outbound calling, this is often expensive or requires far more staff than is typically available in a small practice or a Federally Qualified Health Center. To address the need to follow up with clients inexpensively, we suggest use of centralized outbound reminder calls.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Provide reminder and outbound calls centrally, especially for smaller practices that might not have the resources to provide these services on their own.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

The expense for some provider practices for putting such an infrastructure in place. Provide this as a fee-based service so smaller practices can share the costs for such an infrastructure among multiple practices.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

Either a centralized administrative entity or a RCCO should be involved in processing payments to providers, based upon standardized rules for quality metrics.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type**. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the 5DAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☐
Care management tool	☐	☐	☐	☐	☐
Care transitions alerts	☐	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☐
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

81) How can Health Information Technology support Behavioral Health Integration?

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful

86) How can the RCCOs support providers' access to actionable and timely clinical data?

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

The ACC Program in Colorado has the potential for testing very innovative approaches to health care delivery, using emerging telecare and telehealth technologies. To this end, MAXIMUS has tremendous interest in testing a model that brings together remote access technologies, Long-Term Services and Supports (LTSS), and behavioral health in a single model. This type of model, hereafter referred to as a "LTSS Telehealth" model, would integrate services to at-risk low-income seniors with chronic conditions and Serious Mental Illness (SMI). We would welcome the opportunity to work collaboratively with a RCCO to implement such a model.

In short, a LTSS Telehealth model would seek to improve preventive healthcare, access to care, and social engagement for underserved beneficiaries with chronic diseases and SMI. We believe a telehealth platform, as well as recruiting, hiring, and training a coordinated team of Telecare Support Navigators, Independence Coaches, and Community Assisters, can result in an innovative, integrated LTSS care delivery system that at once improves outcomes while reducing costs. The model's telehealth technology would enable beneficiaries to stay connected and allow appropriate care measures to manage and prevent incidents before they become life threatening or require hospitalization. The RCCO model being used in Colorado offers an excellent test bed to determine the efficacy of this approach.

The goals of the model would be to:

- Help beneficiaries remain in their homes longer and delay costly nursing home admission
- Preemptively prevent adverse events including hospital admission, re-admission, emergency room usage, falls, chronic disease complications, and other incidents
- Better target the growing scarcity of Personal Care Assistants (PCAs) and enable the existing supply to be used more effectively across a greater number of seniors
- Encourage the use of family caregivers by providing safe and responsible respite so family caregivers can address their own needs, and therefore be more likely to take on this responsibility.

Components of the model could include:

- **Technology Platform:** We would use a technical platform that includes three components: remote sensors, vital sign monitoring, and video conferencing. The remote monitoring includes sensors in people's homes, which are non-intrusive monitors that monitor sleep patterns, toileting, food spoilage, and movement within the home. Additionally the platform allows the plug in of a variety of devices to monitor vital signs. A data hub aggregates and reports on this data, creating various types of alerts to identify readings that are normal, of concern and requiring closer monitoring, or indicating need for immediate action. Using the video conferencing functionality, Case Managers can schedule and conduct telehealth consults with remote providers from Medicaid client homes, as well as access video presentations and distance learning resources on chronic conditions self-management. It also includes capabilities to enhance social interaction, supplying music, pictures, memory games, and other forms of entertainment to address social isolation.
- **Call Centers:** By adding some appropriately trained staff to an in-place call center, piggybacking on the existing infrastructure, we can provide conflict-free monitoring services. Telecare Support Navigators monitor reports via the web, and receive specific alerts that result in placing a call to the individual at home, and, depending upon the results of the follow-up call, initiating some type of action. Pre-determined physician-developed protocols specify the appropriate actions – dispatch of emergency services, consultation with a medical home case manager or community health team, call to a family caregiver or Personal Care Assistant (PCA), reminders to take a medication or initiate capture of a vital sign, or scheduling a telehealth consult.
- **Independence Coaches:** Independence Coaches address the social issues limiting the ability of the elderly to age in place. Recruited from the local community, they provide counseling, problem solving, and health coaching to assist participants with maintaining their independence and safety in the home and community. Independence Coaches provide information and access to a range of services – while acting as a key resource to fight social isolation and promote independence. Coaches configure the telecare platform to meet specific needs of individual participants; train them on the use of this technology; conduct weekly or more frequent virtual visits with their assigned participants; help the participant sign up for relevant distance learning, discussion groups, and webinars; and instruct their participants on the use of the secure video conferencing to help them communicate with family members or others in the community with shared interest. They are also responsible for helping the participant to arrange temporary services, as needed, and dispatching the appropriate service provider.
- **Community Assistors:** To make appropriate services available "as needed", we recruit local individuals available to provide paid part-time and/or volunteer assistance, using software to identify resources that best match participant need and assistor availability. The Independence Coach can identify and dispatch a resource to provide the assistance when and where it is needed. The software maintains the hours each "assistor" is available and the duties the assistor is willing to perform (such as shopping, cooking a meal, going to the drug store, doing laundry, installing a hold bar, or providing transportation to a doctor or therapy appointment), enabling the participant to get the in-person assistance when it is most needed. Community Assistors can be dispatched by text messages based upon proximity to the participant, providing a convenient resource to supplement PCAs.

Importantly, a LTSS Telehealth model could bring together technologies, care coordination strategies, health education, and community assistance to help people age in their home and more successfully overcome the challenges of chronic diseases and behavioral health issues. While other programs have focused on some aspect of this model (telehealth, care coordination, health education, community supports, and so on), virtually no other program brings together all of the different components into an integrated approach to aging in place.

We believe it is critical for such a model to address both medical and social determinants of health. While there have been multiple projects that include some aspect of tele-monitoring, none combine all of the components proposed in our approach. A pilot could combine monitoring of chronic diseases with the education, support, and coaching needed to engage beneficiaries actively in the management of their own health conditions, allowing themselves, their caretakers, and their providers to work collaboratively to take necessary preventive measures to avoid more costly medical interventions. A technology platform and call center could provide the ability to monitor chronic conditions continuously, ensuring compliance with treatment regimens through virtual monitoring and outbound reminder calls, while alerting a Medical Home immediately when adjustments to treatment may be needed because vital signs are outside established norms. By enabling in-home primary and specialty care consults via the video conferencing, beneficiaries can get the health care they need quickly and cost effectively, eliminating missed appointments due to long drives to the clinic, lack of transportation, and limited access to specialty providers. These factors often adversely affect the health of beneficiaries in rural environments and lead to more complex, costly medical interventions.

In addition to the successful use of technology, there should be an emphasis on the "human element" to further drive technology adoption. From our research, we found that several pilots providing just technology for senior's use have been less successful than anticipated. In fact, one specific pilot in California was discontinued because the seniors were reluctant to make use of the technology platform. In response to these negative outcomes, models should include a good deal of human interaction and support for use of the technology. Telecare Support Navigators, Independence Coaches, and Community Assistors could be a vital part of a model design.

As an example, although the technology platform can provide automated medication reminders, Telecare Support Navigators can perform outbound calls to ascertain why medication was being missed and encourage beneficiaries to take the missed medication. The purpose of the Independence Coach is to focus on the social needs of the beneficiaries. The Independence Coaches can customize the platforms with social activities, pictures, music, and memorabilia relevant to the specific beneficiaries to encourage them to use and benefit from the platform. Further, Independence Coaches can go into beneficiaries' homes and make sure they understand how to use the technical platform for multiple purposes and provide hands-on coaching to encourage its ongoing use. Through the virtual visits, the Independence Coach can continuously follow-up with the beneficiary, establishing a real relationship with the individuals, helping them to address problems as they arise that may prevent them from remaining in their homes, and finding ongoing ways to use the technology to keep the beneficiary engaged in social and intellectual pursuits that address social isolation and other negative social determinants. Finally, the Community Assistors can provide "on the spot" services when and where they are needed – using technology, but providing capabilities that would not otherwise be available if only the technology were in place.

MAXIMUS would welcome the opportunity to work with the ACC infrastructure to implement such a model to test its effectiveness in this environment.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 093

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

ACC Request for Information

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Greg Hill, Executive Director
Location: Greenwood Village, Arapahoe County, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Dental Association
Location: Greenwood Village, Arapahoe County, CO
☑ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☑ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☐ Yes
☑ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

In Colorado, children have had a long-standing comprehensive dental benefit under Medicaid. The children's benefit does not have an annual dollar limit (though there are certain frequency limitations on services). In July 2014, Medicaid added a limited dental benefit for adults, capped at $1,000 per fiscal year (dentures, when applicable, fall under a separate cap). Based on this new benefit, the dental profession has been increasing capacity to see Medicaid patients. The Colorado Dental Association has supported these efforts through recruitment and communications efforts.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Care Coordination

12) What services should be coordinated and are there services that should not be a part of care coordination?

Oral health is a critical part of overall health for both children and adults, and should be included in care coordination. See Response to Question 48 below.

Network Adequacy and Creating a Comprehensive System of Care

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

Oral health is a critical part of overall health for both children and adults, and the Colorado Dental Association is pleased that the Department has recognized a need to increase the integration of oral health with other healthcare services (physical and behavioral health) in its most recent RFI.

Oral health has historically been approached as if it was disconnected from the rest of the body. As a result, oral health is often segregated from the other health professions. In 2000, the Surgeon General reported on the epidemic of oral diseases in the country. The report raised awareness about the scientific evidence linking oral health to other chronic diseases (diabetes, heart disease, and others), general health and quality of life. Despite this evidence and awareness, little has been done to integrate oral health into the health care system and consequently "bring the mouth back to the body".

Much time and energy has been invested in implementing the "medical home" concept defined by the American Academy of Pediatrics in 1992. Health care provided to patients in a medical home environment has been shown to be more effective and less costly in comparison to emergency care facilities or hospitals. A parallel concept exists in oral health and is known as the "dental home." The establishment of a dental home may follow the medical home model as a cost-effective and higher quality alternative to emergency care situations. A "Dental Home" means oral health care that is delivered in a comprehensive, continuously accessible, coordinated and family-centered way by a licensed dentist. Additionally, a Dental Home includes referral to other dental specialists when the pediatric or general dentist cannot provide the needed care. Children and adults who have a dental home are more likely to receive appropriate preventive and routine oral health care. While dental home initiatives are often focused on children, they can also be extended to other at-risk populations and the population at large. Referral by the primary care physician is a primary means by which the dental home is established.

In the upcoming ACC rebid, Colorado has a prime opportunity to begin to integrate oral health into the overall health equation through concepts like the dental home, as well as initiatives to coordinate dental care. The Colorado Dental Association would like to see the RCCOs charged with beginning to integrate not only physical and behavioral health, but also oral health in the next phase of the ACC. Realizing that dental care has typically been segregated from the rest of healthcare, there are a number of barriers to overcome such as:

- Oral health is often not considered a central component of primary care in the US.
- Patients are often unaware of the impact of oral health on their general health.
- Care coordination between dental and medical offices is often unavailable, even if such offices are co-located.
- Dental insurance is usually separated from medical insurance. (Or in the case of Medicaid, the administration of the programs is handled separately.)
- Dental and medical electronic records do not communicate with each other.

Given these and other barriers, we would recommend some basic standards around dental care integration for this next phase of the ACC. For example, the RFP could require applicants to detail how they plan to begin to integrate oral health care into the PCMH (with an outlook towards having every patient connected with a dental home in the future).

Some ideas from other markets for current consideration by the RCCOs may include:

- Incentivizing colocation projects where full dental services or just prevention and screenings are provided within the primary care office (some locations even joint schedule "max-packed preventative visits" where, for example, an annual or well child exam involves medical, dental and behavioral health screenings as well as vaccinations all in one visit)
- Adding oral health to case management services (even if targeted to specific populations to start, such as children, developmentally disabled, adults with concurrent conditions, nursing home residents or elderly, etc.)
  For example, in Tompkins County, NY, a dental case management program was piloted to increase dental access for children under 6 years old enrolled in Medicaid. This program utilized a dedicated case manager to alleviate administrative burdens on health care providers and maintain a communication portal for families. The case manager provided a variety of services including resolving billing and payment problems, educating patients, and assisting with patient transportation to appointments. The program showed an increase in access to dental care for Medicaid-enrolled families from 9% to 41%. This program also resulted in an increase in the number of dentists accepting Medicaid patients in the county. The case manager was also able to increase oral health literacy and treatment compliance among patients.

However, we would also recommend that the RCCOs be given sufficient flexibility to allow innovation and creativity in their approaches. The "pilot programs" pursued by the RCCOs in this next phase of the ACC could be evaluated and best practices incorporated as requirements in future rebids.

To ensure oral health integration is a priority, the Department should consider providing an appropriate PMPM to the RCCOs for dental care coordination.

In terms of network adequacy and attracting a robust network of high quality providers, it is also critical that dental reimbursements be evaluated. In 2013, the CDA launched a program called "Take 5" to recruit dentists to enroll as Medicaid providers to help treat the underserved in our state. While many dentists want to help and have agreed to treat a limited number of Medicaid patients in their communities, one of the biggest barriers to broad dental provider participation in Medicaid is very low provider reimbursement rates (see data included below). Accepting a large volume of Medicaid patients is unsustainable for many practices due to this financial imbalance. Colorado Medicaid reimbursements are below the national average reimbursement for Medicaid. The overhead costs of an efficiently run dental or dental hygiene office are usually at least 65% of the practice's operating budget. (Overhead costs for dental offices more closely mirror the overhead costs of hospitals or surgical facilities than those of physicians due to the surgical and technical procedures that are routinely performed in dental offices.) However, Medicaid reimbursement for dental procedures in Colorado is less than 50% of the average usual and customary fees for the region – fees that are based on the costs of sustainably operating a practice. (In contrast, most primary care medical practices are being reimbursed at the Medicare rate of approximately 85% of usual and customary fees though overhead expenses are typically reported to be much lower for these practices). These low rates mean that a dentist or dental hygienist must often lose money on a procedure in order to treat a Medicaid patient. Given these factors, dental professionals too often face the difficult

decision of limiting the number of Medicaid patients they can treat in their practice or choosing not to participate in the program at all. States that have increased Medicaid dental reimbursements closer to market levels typically avoid these challenges and easily maintain a robust provider network.

Adult Dental Medicaid Reimbursement Rates in 2014

- **Colorado's dentists are committed to reducing barriers to dental care for all Coloradans.**
- **In the past, many dentists have provided uncompensated care to Medicaid-eligible Coloradans because of billing issues and low reimbursement rates. As a new dental benefit is launched for Medicaid adults, we have sought to address many of the administrative barriers that prevent dentists from participating as Medicaid providers. Improvements include outsourcing administration of the Medicaid dental benefit to a private vendor (an administrative services organization).**
- **<u>But still, in 2014, Dental Medicaid pays dentists in private practice less than 50 cents on the dollar for providing care to Medicaid-eligible adults.</u>**
- **Dentists will treat more Medicaid-eligible adults if barriers to care, like very low reimbursement, are addressed.**

Common Dental Visits	Medicaid Reimbursement Rate for Private Practitioners[1]	Community Health Center Reimbursement Range[2]	CHP+ Reimbursement Rate[3]	Average Private Market Reimbursement Rate[4]
Emergent Care Visit[5] (Extraction)	$112	$140 – 230	$144	$226
Restorative Care Visit[6] (Dental Filling)	$83	$140 – 230	$119	$171
Preventive Care Visit[7] (Cleaning and Exam)	$86	$140 – 230	$136	$180

<u>Sources:</u>

1. HCPF Dental Program Fee Schedule, Effective July 1, 2013.
2. Approximate range of FY 2013-2014 reimbursements based on figures provided to the Joint Budget Committee for FY 2014-2015 figure setting. FY 2013-2014 average reimbursement was $173.
3. Delta Dental 2014 PPO Fees, Region 1, Pediatric.
4. Mean Fee Data from the American Dental Association's 2011 Survey of Dental Fees, General Practitioners: Mountain Region.
5. Dental codes used for "Emergent Care Visit:" D0140 (limited oral evaluation – problem focused), D0220 (intraoral - periapical first film), and 07140 (extraction, erupted tooth or exposed root removal)
6. Dental code used for "Restorative Care Visit:" D2331 (resin-based composite – two surfaces, anterior)
7. Dental codes used for "Preventive Care Visit:" D0274 (bitewings – four films), D0120 (periodic oral evaluation - established patient), and 01110 (prophylaxis – adult)

References

American Association of Pediatric Dentistry. "Patient Centered Care." 2013. http://www.aapd.org/assets/1/7/PatientCenteredCarePolicyBrief.pdf

American Association of Public Health Dentistry. "TOWARD A COMPREHENSIVE HEALTH HOME: integrating the Mouth to the Body." 2012. http://aaphd.membercilcks.net/assets/resolution-statements/aaphd%20final%20health%20home%20resolution%20-%20last%20revision%20oct%202011.pdf

National Network for Oral Health Access. "Oral Health and the Patient-Centered Health Home." 2012. http://66.147.244.144/~nnohaorg/nnoha-content/uploads/2013/09/PCHHActionGuide02.12_final.pdf

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 094

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Elizabeth Hickman, Ph.D.
Location: Yuma, Yuma, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Centennial Mental Health Center
Location: Admin office Sterling, CO, but providing services to Cheyenne, Elbert, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington and Yuma Counties
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Mental Health and Substance Use Disorder treatment provider organization
  ii. Area of practice: Community behavioral health
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☒ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?
☒ Yes

If you answered "yes" above, how long?
☒ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Centennial has participated in care coordination teams whenever possible within RCCO 2; we have shared population data to "match" for RCCO 2 attributed members who have history of treatment at our agency. In both RCCO 2 and 7, we have engaged in higher level discussions about how to optimize positive impact of the ACC principles in our rural/frontier counties, and in RCCO 2 we join the Northern Colorado Health Alliance in monthly review and planning regarding RCCO functions.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Past provider and co-owner of Northeast Behavioral Health Partnership (BHO); current provider within Colorado Access Northeast BHO.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?
☒ Very likely

We are strong believers in the value of effective integration and care coordination to help maximize positive impact on both individual client care and population health. We have participated as actively as we were able, given the structure of the RCCO and "PCMP" options up to now and look forward to additional roles we can take in the future.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

At least in RCCO 2, it took a very long time to really build out the network of associated primary care practices for attributed members beyond Weld County. The good news is that I believe all counties are finally represented by primary care options, and at least in some of our counties, our center is actively represented in the care coordination team.

In RCCO 7, our agency is finally getting looped into efforts in Elbert County, which was at best an afterthought in that region's implementation. The good news there is that Peak Vista has now acquired the smaller FQHC that previously served Elbert (and Lincoln) County, so there will likely be better engagement of the RCCO 7 efforts in Elbert County.

2) What is not working well in the ACC Program?

There are challenges in developing the ACC framework in our rural/frontier counties and I believe there have been perhaps unintended barriers to really fully integrating efforts with our agency which is the "face" and practical reality of the BHO in the Northeast. I think there is a good chance that allowing for earlier involvement of community mental health centers (CMHC's) as designated PCMH's could have moved such enhanced care coordination into all of our counties much quicker. Even now, unless the contracted PCMH is part of a much bigger system (e.g. Salud or Banner Health), they are unlikely to have the local staff to serve direct care coordination functions, and there does not seem to be a smooth way that CMHC's can quickly contribute to the boots on the ground care coordination, even around our own clients. I believe some of the other RCCO's have found ways to bring CMHC's into the service and care coordination "mix" in some different and likely more effective ways, but in RCCO 2, we have been eager from the beginning to contribute more than we've been able to do.

The lack of alignment of regional boundaries from the ACC to the BHO system has been a barrier to the best coordination of care in those counties caught between, including Elbert County that for the first several years of ACC implementation was largely forgotten in the RCCO 7 effort. Until the major FQHC in RCCO 7 acquired the smaller FQHC serving Elbert County, there was really no logical pattern of medical services tying Elbert County Medicaid members to the rest of RCCO 7. Such "illogical" boundaries around the original ACC regions is even more pronounced in Larimer County which got cut off from the rest of the northeast region and paired with the Western Slope, in complete disregard for both geography and natural flow of medical services in the area.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

The BHO risk-based model has for many years been an effective structure to help ensure availability of quality services in the community for individuals in need, and to do so in a cost-effective way. As a consequence, the cost curve for Medicaid BH services has been much lower than healthcare as a whole. Although the capitation model continues to tie back closely to overall "encounters", at least it has provided a base to operate from, even in our widely dispersed rural/frontier counties. That same encounter based model initially complicated tracking and justification for more and more "integrated" services bringing BH into primary care practices, but the "carve out" contract has nonetheless allowed BHO's and their providers to take the risk to develop these alternative service sites and ways of delivering care to more Medicaid members. We worry that consideration of a "carve in" model of the future would fair very poorly, especially in our rural communities, where the breadth and depth of services needed for Medicaid members would be impossible to ensure. Ultimately, we believe that there may be an answer somewhere between that will allow the "best" of the BHO functions to remain, yet allowing for the necessary flexibility and coordination to best operationalize integrated care in our communities.

4) What is not working well in the BHO system?

The BHO major providers like CMHC's are facing workforce challenges across virtually all provider types who provide both MH and Substance Use Disorder services. Some barriers exist in getting folks from out of state quickly credentialed, and we could absolutely make good use of increased programs for health shortage areas like loan repayment. Retention of good providers is also made more difficult by increased competition for the same workforce from broader health care systems that tend to pay at a higher level commensurate with long-standing higher "value" of medical vs. MH procedures.

Safety net funding in the state (Medicaid and OBH) could, and should, be better aligned so that goals toward best outcomes and overall population health would be consistent and supportive of integration.

5) What is working well with RCCO and BHO collaboration right now?

Although slow to really develop in our rural counties, there gradually is more collaboration and intent to coordinate care well, at least for those highest in medical need. Initial efforts to share BHO, CMHC-specific and RCCO 2 data to identify common members languished, but have now been rekindled and will hopefully lead us forward more productively.

In RCCO 7, our BHO/CMHC is becoming more involved in active collaboration around BH service delivery and care coordination as well.

6) What is not working well with RCCO and BHO collaboration right now?

In RCCO 2, even with both the RCCO and BHO now being contracted with Colorado Access, there is too much separation and potential redundancy around aspects of care coordination that I believe could more effectively and efficiently be done by local CMHC staff, who could provide more regular in person contact, versus RCCO care coordinators that travel out to our rural/frontier counties once a month. I hope that future RCCO guidance will incentivize if not mandate such coordination with local providers.

Challenges also remain around the sharing of data, partly due to limitations in the SDAC system, but also around barriers to CMHC's being able to get relevant health care data on their populations and specifically

on the clients they are serving. If CMHC's are allowed to become designed PCMH's, that barrier would be reduced.

There also remain issues around member-specific sharing of substance use data due to 42-CFR part 2 that ultimately may need Federal level change, but can generally be worked around with appropriate releases for actual care coordination.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Ideally, we would be working toward alignment of goals and systems across all major players in health care in the state, including BHO, RCCO and health insurers—hopefully with the support of the pending "SIM' grant—where services, finance, and data all are aimed toward the best health outcomes that serve both the individual patient and population health. However, such alignment in processes needs to be "lean" and only what is truly necessary to monitor effective outcomes and overall oversight for public dollars, as over regulation will not serve either the state or population goals.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	Barrier? No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	OBH funding does not really support effective integration of BH into physical health care. BHO funding is more robust, but we still need to work on opening up all relevant codes and move past limitations of covered diagnoses.
Community Behavioral Health Services Rule	☒	☐	They are generally aimed at traditional outpatient CMHC type clinics, so sometimes just miss the mark in an integrated care situation.
Covered diagnoses list	☒	☐	BH providers should be able to effectively assist with behavioral challenges across all diagnoses, including but not limited to MH or SUD disorders. With the overall goals of Medicaid in our state, exclusions of individuals with TBI, autism spectrum, developmental disabilities and the like are misplaced.
Different behavioral / physical health reimbursement	☒	☐	I believe that ultimately physical health care will need to incorporate more of a risk-based reimbursement model as the BHO's have operated with for years.
Institutions for Mental Diseases exclusion	☐	☐	unsure
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	At least some aspects on the OBH side are redundant, often irrelevant to goals of population health and at times burdensome; HCPF and BHO contracts have some rules and requirements that still get in the way (see above) but generally are a bit easier to work with.
PCMP financing structure	☒	☐	Up to now, it has left out the possibility that CMHC clients could prefer to have all of their health care coordinated through the CMHC, whether or not the physical health care is actually delivered on site at the CMHC.
Per-member per-month amount	☒	☐	It is enough to help support efforts, but without being able to blend in some of our same staff and resources supported from the BHO side, I'm not sure how our CMHC would be able to "play" in the overall effort.
Physical space constraints	☒	☐	We are building a new facility in one of our biggest population counties (Morgan) that will be able to house a physical health care unit, but in our existing facilities,

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

			finding space to conduct more than routine health screenings is a significant challenge.
Privacy Laws (HIPAA, 42 CFR)	☒	☐	As mentioned above, 42 CFR part 2 requirements around release of SUD specific information on clients is still challenging. OHCA and BAA arrangements seem satisfactory in addressing most HIPAA requirements.
Professional / cultural divisions	☒	☐	There is no doubt still a bit of a divide between behavioral health and physical health providers, but the only way past that is a bit of training and a lot of experience in the trenches together.
RCCO or BHO contracts	☒	☐	I would suggest future RCCO contracts include even more clear expectations to work closely with the BHO and its primary provider network in order to meet the expectations for care coordination and effective interventions for behavioral health. I am not sure if it is possible, but I would recommend you consider requiring the BHO through its providers to be the "default" source of care coordination out in the field.
Staff capacity	☒	☐	Every CMHC in the state is challenged with gearing up its workforce at the present time, but we are all investing more all the time in integrated care directions. Ideally, our local state colleges would get in tune with integration and do a better job in the future of training professionals for this work as well!
State/Federal rules or reporting requirements	☒	☐	See above regarding OBH rules/reporting specifically.
Technical resources / data sharing	☒	☐	SDAC has its own limitations, but we recognize that our current EMR also has gaps that our next generation electronic record will help us address. "Meaningful use" will hopefully be more than a concept in the future!
Training	☒	☐	In addition to better new professional training in this integrated care world, we are in process of identifying the right level of training to gear up our existing work force to better interface with our primary care colleagues in general, as well as training for our staff serving in primary care clinics. I think this is a realm ripe for cross-fertilization in Colorado.
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

There are wonderful models out there for integrated care that typically involve a continuum from a position of disconnected entities providing uncoordinated care to a person, up to a level where there is a completely integrated service in one location supported by integrated funding. The SAMHSA-HRSA six-level model is one such approach that gives us a great way to gauge where we are and an idea of what to strive for.

However, this should not become the only way in which HCPF recognizes a health care entity as a Patient Centered Medical Home/Provider. Any health care entity, including but not limited to CMHC's, willing to provide a significant portion of an individual's health care services and actively coordinate the rest should be eligible. HCPF historically has used a "medical home" designation that was achieved through demonstration of active care coordination and collaboration in behalf of children served, a concept that reflects well what is required to bring care together to the benefit of the "whole person". A simple expansion of the age range would provide an alternative way to recognize a given clinic in this vein.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Behavioral health integration will look differently across the state based on many factors, including resources and demographics. It should be a goal that is more "process" than a specific place on a continuum.

We also need to make sure that telehealth delivery of behavioral health is considered equivalent, as this is one very efficient and effective way to provide virtual on-site behavioral health support to primary care practices across the big geography of Colorado.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

At a system level, it involves ways of identifying which clients may benefit from additional support. At the client level, it is in essence getting to know the "whole person" well enough to help them identify additional needs based on their personal goals for their health and functioning, then helping them get connected to other medical, behavioral and/or community resources that will address those needs.

b. How should RCCOs prioritize who receives care coordination first?

It is my understanding that RCCOs typically use medical cost data to help identify individuals with high needs (e.g. the "hot spotter" model), and for overall purposes that probably works okay. However, there should certainly be an alternative referral path, including provider or self-referral, as well as consideration of other factors beyond system cost that drive the setting of priorities.

c. How should RCCOs identify clients and families who need care coordination?

See answer to b. above. Ideally the identification process can be multi-faceted, and cost factor is just one consideration in establishing "priority".

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

I am not familiar with how this may be happening now, but would hope that such tracking could be done, as much as possible, within the existing records and reporting requirements that the delegated provider already provides for their Medicaid clients.

12) What services should be coordinated and are there services that should not be a part of care coordination?

If care coordinators are really coming to understand the whole person and their needs, there may well be assistance needed in ways that are far outside the typical health care "box", and as long as the solution is legal and within reason of cost/time, I believe the more flexibility the better.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

Overall known/suspected health care challenges, a survey of their family/social resources, ability to transport oneself, any other self-perceived barriers to following through on health goals, and what the local array of formal and informal resources are in the community.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

We are already often crossing care coordination pathways, which potentially can be problematic and redundant at best. For some of our clients, they have may have coordination within their SEP or community centered board, our CMHC and/or the BHO, as well as the RCCO.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

Care coordination within the CMHC environment has historically focused on helping that client recover optimal functioning by looking at all aspects of their life and assisting them to make best use of the appropriate (or mandated) community resources. The latter, depending on age and/or situation, might involve schools, courts, probation, human services, family resource centers, etc., along with health care providers.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

Quickly identify if there is an existing or better point of contact for a particular client to serve as the care coordinator. In some situations, I could imagine a need for the RCCO to also have some follow up with a client, but I think in the great majority of circumstances, clients would be better served by having ONE care coordinator that is supported behind the scenes around details that they may not have immediate knowledge of.

d. What are the gaps in care coordination across the continuum of care?

Primary care has historically not been strong in "whole person" care, and unless they were part of a big enough system to have a hospital social worker, there was seldom an identified resource person to meet the needs that did arise. This is improving, through RCCO efforts and otherwise, but there are still gaps there, particularly if the client's medical needs have not pushed them to the "hot spot".

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☒	
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	Knowledge of any programs that provide added support and/or assistance in applications needed; linkage if needed regarding formulary issues.
Daycare / childcare	☒	☐	☒	
Economic stability & employment	☒	☐	☒	
Education	☒	☐	☒	
Environment	☒	☐	☒	
Food access / nutrition	☒	☐	☒	Source of information if not available from local resources.
Health literacy	☒	☐	☒	Ditto food access.
Housing	☒	☐	☒	
Language or translation services	☒	☐	☒	
Literacy	☒	☐	☒	
Transportation	☒	☐	☒	An important support as needed in rural counties where public options may be non-existent.
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	
Certified Addiction Councilors	☒	☐	Counselors please...
Certified Nurse Midwives	☒	☐	
Community Health Workers	☒	☐	
Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☒	☐	
Licensed Mental Health Counselors	☒	☐	
Licensed Professional Counselor	☒	☐	
Masters of Public Health	☒	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	
Nurse Practitioners	☒	☐	
Patient Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☒	☐	
Psychiatrists	☒	☐	
Psychologists	☒	☐	
Registered Nurses	☒	☐	
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	

Other	OVERALL COMMENT: The ROLE of a care coordinator could be met by any of the above individuals. The core quality is probably not degree dependent, but rather has to do with the level of empathic connection and ability to help motivate and encourage the individual toward more healthful choices, as well as the knowledge base to steer them toward other health, human service and community resources that can help them.

17) Care coordination requirements for specific populations. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☐	
Children	☒	☐	
Children who are healthy, but in socially-complex environments	☒	☐	
Children involved in the foster care system	☒	☐	
Children with a chronic illness	☒	☐	
Children with a serious emotional disturbance	☒	☐	
Children with medical complexity	☒	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	
Transition-age adolescents	☒	☐	
Parents and families	☒	☐	
Pregnant women	☒	☐	
Adults	☒	☐	
Adults who are healthy, but in socially-complex situations	☒	☐	
Adults with a chronic illness	☒	☐	
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	
Clients involved in the criminal justice system	☒	☐	
Clients with a disability	☒	☐	
Clients in a nursing facility	☒	☐	
Elderly clients	☒	☐	
Frail elderly clients	☒	☐	
Clients in palliative care	☒	☐	
Other populations, please comment: OVERALL COMMENT: The best care coordination for any and all of the above populations is going to be enhanced by someone with at least some familiarity with some of the specific needs and/or barriers to care for these populations. That does NOT necessarily mean that each of the above populations would need someone only providing care coordination for others in that same realm, but some basic familiarity would be needed. Some of them also group naturally together, for example in the array of specific children populations noted. As noted above in # 16, if care coordination is conducted by the person/system most relevant to the client, this issue will naturally be addressed.			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

As stated above, it is our belief that care coordination will best be conducted by, or in very close concert with, the health care provider system closest to that individual. In the case of foster children, some human service entities may also have capacity, but at the very least, need to be providing a lot of information and support to make sure the care coordinator has the big picture for the client.

19) How should care coordination be evaluated? How should its outcomes be measured?

Some of the existing outcome measures (e.g. reduction in cost) are valuable, but there are also client perceptions that are likely important to the continued optimal delivery of health care to that client—not just "satisfaction" per se, but variables like increased knowledge of their condition and reported decrease in barriers to medical compliance.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

Unsure, as BH providers our care management/coordination is delivered under a much different "at risk" capitation model, and one of many services delivered to a specific client. Our center probably spends conservatively $35/month for targeted clients (e.g. those with SPMI) for care coordination, and much more than that when an individual is going through a situation requiring much more support and coordination efforts.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

If care coordination is going to be targeted to specific populations, it certainly makes good common sense to acknowledge the differential time and hence cost of providing care to high needs clients vs. routine health care, but I have no specific recommendation on how much this PMPM should vary.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

Unsure, and in general, the less RCCO's are tied to specific requirements and the more their success is measured by outcomes, the better.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Fewer than 25, if considering active "high risk", "high cost" during the targeted period; possibly closer to 51-100 if totaled over a year's time.

Clients	
Fewer than 25	☒
26-50	☐
51-100	☒
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

Improvement in client's objective health status

Improvement in client's reduction in isolation and/or suffering in dealing with their health condition; or in other words, their sense of encouragement and support.

Reduction in overall health care costs

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Keep the option for care coordination to be conducted closest to the client and their main source of health care, including CMHC's as appropriate to a given client. Keep the ACC/RCCO framework as flexible as possible for what works best for a given region AND a given client or patient. Don't over-regulate, but instead develop a framework where the health care providers and the RCCO have "skin in the game" to positively incentivize offering the most effective and efficient care.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

As much as possible, local flexibility should be allowed so that the RCCO and contracted providers can best address the needs of their communities. Regulations should be "lean" and aim at the big picture requirements instead of specific functional requirements.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

The real ability to create such community relationships in a similar (if not the same) targeted RCCO area. Urban expertise is not equivalent to rural expertise, just as one case in point.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

I cannot imagine that this would lead to a stronger regional system.

27) Should the RCCO region maps change? Why or why not? If so, how?

Consider redrawing boundaries to match obvious geography and/or patterns of seeking healthcare. Elbert County and Larimer County should never have been moved away from the rest of the Northeast that became RCCO 2.

28) Should the BHO region maps change? Why or why not? If so, how?

The BHO regions were historically established around prior MHASA's which were groupings of MHC's. I would see no value in them changing at this point.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

Unsure.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

Unsure, other than resolution of 42 CFR as noted in previous question.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

Continuous benefits are critical to continuity of care and hence better health outcomes.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

This does not make sense to me. I don't believe this arena of health care needs "competition" to work better.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

We have been a Medicaid provider for many years.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

Clients should be attributed to the PCMP that can best meet their needs, including a CMHC when appropriate, so the RCCO role would be one of providing information on options and helping, as needed, with the logistics to make that happen.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

Programs that address population health goals across the region.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

Some human services may be an integral part of improving a client's health and functioning in the community. Both DHS and HCPF funding should support this interface.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

At the very least, cross referral to make sure that all Colorado residents are ultimately covered by health care benefits from Medicaid or 3rd party insurers.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

The ACC program is in unique position to help identify and recommend solutions to unintentional barriers to effective integration, including ways to streamline regulatory requirements between physical and behavioral health systems. The ACC can also work with DORA to help streamline and speed up licensure of qualified health care professionals moving into Colorado from other jurisdictions.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

RCCOs at least via their care coordinators should have active and ongoing involvement from clients, families and advocates; this will be easier if care coordinators have an established local presence.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

Each community has some unique qualities, and RCCOs would be well served to bring these community groups together to help "design" the community implementation of the RCCO.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

Get input and feedback on the community RCCO back to the broader community and not just the PCMP(s).

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Make sure that systems that overlap with the ACC for the benefit of members are all involved in refining the second RCCO contracts, including systems like BHO, SEP, CCB, etc.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

There are shortages of virtually every licensed behavioral health provider, including psychiatrists and mid-level prescribers. As noted previously, the ACC's should help address barriers with DORA. Additionally, telehealth provision of services is an essential "gap-filler", so bidders and providers should be acknowledged for such capability.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

My response for all of the above is virtually identical, so I will respond generally here. All of the above service entities/providers potentially play absolutely key roles in achieving the "triple aim" and should, at a minimum, be surveyed and invited to local/regional stakeholder participation to help refine the next RCCO contracts. After contracting, these groups similarly should all be part of development of additional aspects of the RCCO implementation, and ongoing program monitoring for success.

45) How can RCCOs help to support clients and families in making and keeping appointments?

This is something that CMHC's have addressed for years, including actively helping remove barriers for clients keeping appointments. Perhaps these "lessons learned" would be of value to the RCCO and/or PCMP's.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

I do think there is great value in CHW's and/or navigators that are very well informed about the community the client lives in. Generally, at least in the systems I'm at all familiar with, these individuals are part of a team in conjunction with the RCCO and/or BHO-CMHC provider so they also have support beyond themselves.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic (inc. **CMHC)**	☒
On staff (salary) at RCCO	☒
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

Helping to encourage other dental practices to participate, identify regional resources, bring mobile services in regularly to communities without Medicaid dental providers and assisting with transports.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

Familiarity and ability to speak and relate well to individuals from the local population "mix" across not only racial and ethnic identities, but also predominant work, socio-economic, industry groups.

b. What RCCO requirements would ensure cultural competency?

   Close working relationships not just with PCMP's in the region, but other providers, resource groups in the local area.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

   A general attitude and approach of openness and non-judgmental response is just one aspect. Multi-language capacity is obviously needed, whether through bilingual staff or portable translation technology. Translating the medically complex into common "lay" language is also an essential skill.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

   At the very least, the RCCO would need to describe and delineate how they would intend to address those barriers themselves, or through their community partners.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

Unsure

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

If RCCO's could assist with making real-time connections between the ER and the community providers involved with a client, this would help redirect such individuals back into their more effective and less costly community-based care.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others	OVERALL COMMENT: Many if not all of the above have their corollaries in the BHO system and/or have been otherwise developed in the statewide CMHC's. They would have benefit to the PCMP's beyond their Medicaid role, but may well be worth supplying or supporting adequately.			

One additional BASIC point of assistance from the RCCO would be around education with medical lproviders around behavioral health treatment, as they are generally not very familiar with how BH supports the broader health care goals and reduce medical costs.

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

Based on BHO experience, I'd say to incentivize the PCMP's to take financial risk in the health outcomes of their clients.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

Unsure

58) Please share any other advice or suggestions about provider support in the ACC.

None at this time

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

Moving toward more of a risk-based model will further incentivize good coordination and good care.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

Centennial MHC within the BHO structure has been operating within such a capitation payment environment successfully for many years. It is a tested design for Colorado and help us meet goals of the triple aim with regional and local flexibility in implementation.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Yes, as long as value is truly outcome based and valid versus just counting services.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

Centennial is not licensed in this fashion, but is part of a regional entity that holds a LSLPN license.

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

Unsure

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

None at this time.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

Improvement in health measures, increased client engagement, provider success, as objectively measured as possible.

66) **Measuring Client experience**. Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	Not familiar with the specific measure
SF-12 Health Survey	☐	☐	Ditto
Other types of client interviews / surveys	☐	☐	Helpful, but tend to underreport as many clients decline participation
Patient Activation Measure	☐	☐	In other words, "engagement" in one's own health? If so, yes!
Focus groups	☐	☐	Something like "appreciative inquiry" would be more highly recommended! Talk to High Plains Research Network.
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

Work with specific communities and stakeholder groups to identify needs and ways to monitor progress; perhaps an effort that could be combined with health departments.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

Stakeholder meetings and updates via email, links to public websites, and the like. Newspaper and other media efforts that attempt to bring the "value" statement back down to the community level and not just at the state level.

69) **Measures for payment**. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐

S1+	☐
None	☐

Somewhat unsure about what to recommend here, but generally believe that such measures are best kept few and simple.

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

Unsure

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Perhaps most should be in common, but at least some regional/local variability would also provide some helpful flexibility.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Both! Use national standards as a baseline and incentivize improvement within reasonable boundaries.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

Unsure, but probably at least quarterly.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☒
Other	☒

If you checked the "Other" box, please describe payment frequency below:

Perhaps a mix of quarterly and annually, depending on the measure and the fluctuations to be expected over short periods of time.

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

Unsure

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Centennial participates in managed care contracts with both BHO and MSO entities and receives reimbursement in part related to measures such as access to care and/or reduction in symptoms.

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☒
Digital care management tool CONSIDERING	☐	☐
Care transitions alerts CONSIDERING	☐	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☐	☒
Practice assessment tools	☒	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☒
Patient education/wellness tools	☒	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☒
Telemedicine software	☒	☐
Other:	☐	☐

Other:	☐	☐

79) **Importance of technology by type**. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☒	☐
Care management tool	☐	☐	☐	☒	☐
Care transitions alerts	☐	☐	☐	☒	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☒	☐	☐
Health risk assessment software	☐	☐	☐	☐	☒
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☒
Patient education wellness tools	☐	☐	☐	☐	☒
Provider/case manager directory	☐	☐	☒	☐	☐
Shared decision-making tools	☐	☐	☐	☒	☐
Telemedicine	☐	☐	☐	☐	☒
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Real time information sharing capacity and some remaining privacy issues (esp. 42 CFR part 2)

81) How can Health Information Technology support Behavioral Health Integration?

The ACC Program should look for bidders willing to invest in technology that fosters integration and can overcome the challenges of the State's data system.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

Both physical health and behavioral health (mental health and SUD) must be addressed.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

Ability to cross over from primary care to behavioral health and/or other systems supporting a client's care.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

Unsure

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

All providers and provider types should be contained.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

Allow the RCCOs to share data outside the existing state data system with provider entities as needed to enable the use of timely clinical data to improve care.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

For clients – very user friendly and smartphone accessible, as well as obviously relevant to their own health goals. For providers and the RCCO – secure but still open enough platform to be able to be used and accessed by range of tech-savvy (or not) providers.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

Ideally, live IT support.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

It's essential that exchange platforms are available to both physical and behavioral health providers. Also, it's critical that the platforms allow for the easy exchange of information, including real-time data that can be used to change the course of a client/patient's treatment.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Keep it as simple as possible and support it.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 095

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

PEDIATRIX MEDICAL GROUP

COMMENTS ON BEHALF OF PEDIATRIX MEDICAL GROUP
CO HCPF- RFI UHAA 2015000017
Accountable Care Collaborative Request for Information

November 24, 2014

Kevin Dunlevy-Wilson
Colorado Department of Health Care Policy and Financing
Accountable Care Collaborative Strategy Unit
1570 Grant Street
Denver, CO 80203-1818

Dear Mr. Dunlevy-Wilson:

On behalf of Pediatrix Medical Group and our affiliated physicians and other clinicians, we are providing the following information and comments regarding your Accountable Care Collaborative Request for Information (RFI UHAA 2015000017).

Introductory Response Worksheet Basics

Name:	John Savino, Regional Director, Managed Care; Sam Grossmann, Director Government Relations
Location:	Pediatrix Medical Group- Regional Office 4722 North 24th Street, Suite 150 Phoenix, AZ 85016

The best description for our organization is: Medical Provider- Pediatric Subspecialty Care and Maternal Fetal Medicine.

We are not currently involved in the ACC program. We have had interaction with RCCCOs through the CHIP program. We are interested in learning more about this next iteration of the program. Please ensure that our representatives above are included on any public correspondence about the ACC, including hearings, provider notices and other pertinent information relevant to physicians and other advanced practitioners.

As one of the largest providers of pediatric specialty care across the country, we would like to be involved in the evolution of the ACC program. We may be able to assist with your efforts, as our practices have collected significant clinical data and other valuable experiences in our clinical fields.

ACC Program Vision- Our Understanding of Core Measures

Our Colorado physicians (and national group colleagues from 33 other states) respect your efforts for delivery system reform. These desired measures of improved health outcomes, reduction of costs, best practices, and use of data and analytics align closely with similar efforts that we have developed in our areas of practice. We are interested in learning more about the various ACC Advisory Committees and Subcommittees designed to deliver improved care and meet quality measures.

Pediatrix Medical Group- Our Experience

As the ACC program evolves, Pediatrix will evaluate the role we need to play within these models. Our organization has always been a "patient centric" organization. As such, our focus on high quality clinical practice and care coordination have always been hallmarks of our service. We have proven experience in utilizing the resources associated with being a national group of physicians and advanced practitioners to improve quality with numerous activities including: data collection, analysis, feedback with remeasurement, clinical education experiences, and collaborative multisite studies to investigate specific clinical problems.

Comments to Specific Applicable Questions on Behalf of Pediatrix Medical Group

Question #40: In terms of specific requirements that RCCOs should have with providers, we believe that the current format with provider representatives has been an adequate model. Our experience in this area has been that "provider representatives" have assisted capably as issues arise. One idea to strengthen the current environment or format would be to have standing quarterly meetings to discuss issues.

Question #44 (c): We are unsure of the exact role that specialists may play in the next iteration of the ACC Program. Our neonatologists do provide care coordination and act as a primary care provider while the baby is under our care.

Question #50: If "preferred networks" is similar to "narrow network", no we would not support having a narrow network because of access to care concerns.

Question #52: We believe that it is important to have access to care, and the state needs to continue to promote adequate networks. Adequate levels of compensation for physicians will create a robust network and ease many access to care issues.

Question #59: The ACC must provide good levels of compensation so that robust networks can be developed and maintained. Incentives based upon quality derived for each specialty is a laudable goal.

Question #61: Providers are in the process of developing the infrastructure of payments being tied to quality. The need for data here along with infrastructure development will be critical. There may be a need for state dollars to assist in this development.

Question #63: Regarding distribution of payments to providers, we believe that the RCCOs should employ the most efficient means of delivering the payments to providers.

Question #65: The type of measures tied to payment is really dependent on the particular specialty under consideration.

Question #69: Our group supports utilizing Key Performance Indicators. One suggestion would be to keep measures to a minimum in the beginning of the program. In this regard, performance measures could be proven before unnecessary expenditure of state funds.

Question #70: Our thought would be 10%-20% of the RCCCO pay should be tied to measures.

Thank you for your consideration of this important matter. If you have any questions about these comments, please contact John Savino, Regional Director, Managed Care at (602) 256-4628, ext. 662 or Sam Grossmann, Director Government Relations at (615) 519-0123.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 096

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

ACC Request for Information

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Jason Greer
Location: Denver, CO

Serial # 096

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Community Managed Care Network (CCMCN)
Location: Denver, Colorado
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☒ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☒ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☒ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:

The Colorado Community Managed Care Network (CCMCN) is a statewide membership association for 13 out of the 18 Federally Qualified Community Health Centers (FQHCs or CHCs). CHCs provide a health care home for almost 650,000 Coloradans, including 28% of all Medicaid enrollees in 2013. CCMCN is a founding partner and Board member in 2 organizations that run 4 out of 7 RCCOs, Integrated Community Health Partners (ICHP, RCCO 4) and Colorado Access (RCCO 2,3 and 5). CCMCN provides data analytics, shared care coordination software and population health strategy for ICHP.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

See response above.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

General Questions

1) **What is working best in the Accountable Care Collaborative (ACC) right now?**

The ACC has made important progress by making strategic investments in the delivery system. It has been a positive step towards improving care coordination and establishing more accountability for outcomes, most notably:

- Financial support for care management has brought focus to high risk populations.
- Partnerships with local hospitals and community partners have been strengthened in some regions, particularly around the Key Performance Indicators (KPIs).
- Medicaid, RCCOs and PCMPs are engaging to improve outcomes and contain cost growth.
- Payment reform is being piloted and conversations are underway about how and when to include additional regions and/or providers.

2) **What is not working well in the ACC Program?**

The following areas for improvement are being actively solved for today:

- Attribution:
  - Too many Medicaid enrollees remain unattributed to a PCMP for too long, decreasing the ability of PCMPs to engage patients and begin implementing interventions to improve outcomes and contain costs. While monthly attribution has addressed some of these concerns, the ACC program should move to auto-assignment for those that remain unattributed after attempts have been made to have them select a PCMP.
  - The process to change PCMP attribution is too burdensome on the patient, and as a result some providers serve as a patient's PCMP without the recognition and financial support provided by accurate attribution. This process needs to be refined to allow patients to change PCMPs in a timely fashion.
- Timely and accurate data is central to a provider's ability to successfully manage population health and make adjustments to improve outcomes. PCMPs and their membership organizations should be allowed to receive the raw claims data as long as they have an appropriate data use agreement and the ability to work successfully with the data.
- RCCO and PCMP relationships vary by region and present challenges for large PCMP systems located in multiple regions. These large PCMPs often find themselves stretched between differing requests and requirements, and varying priorities and strategies which are not always consistent between regions.
- The ACC program could require that a minimum percent of the RCCO budget be allocated to providing care and not for admin to be assured that there are adequate dollars going to provide support to providers.
- Hospitals will need to begin playing a significant role in the ACC to achieve the desired outcomes of better health care at a lower cost. Incentives for hospitals could be included in the next iteration of the program.

3) **What is working best in the Behavioral Health Organization (BHO) system right now?**

Similar to the ACC, CHCs have seen both areas of success with the BHO system and areas in need of significant change. A few successes to highlight:

- Access to behavioral health care is expanding in some areas as Community Mental Health Centers (CMHCs) are hiring staff and working to meet the increased demand created by Medicaid expansion.
- Partnerships between CMHCs and CHCs are very strong in some areas, resulting in improved access to behavioral health services through the integration of CMHC staff into CHC care teams, and in a few places, improved access to primary care by bringing CHC staff to the CMHC.
- The launch of the statewide crisis response system is filling a gap and providing a service that was not available in the state before now.

4) **What is not working well in the BHO system?**

Overall, the focus of the BHO program on covered diagnosis and procedures does little to support integration in the primary care setting, where the behavioral health needs of patients don't always fall neatly into a diagnosis. PCMPs are ideally situated for providing preventative care and early interventions, but PCMPs must navigate complicated and varied CMHC/BHO relationships and billing procedures to receive payment for this care. Access to behavioral health care for Medicaid patients seems to be improving but continues to vary by community.

The separation of funding for behavioral health care from medical health care, does not allow for the alignment of incentives to improve care. Integrating the funds for medical and behavioral care (e.g. ending the carve-out) will make both service provision and access to care more efficient and patient centric. Money should follow the patient, meaning if a patient receives their behavioral health care at a CHC, the CHC should be able to bill a single entity for care. In addition to the need to integrate funding, the following issues need to be addressed:

- Access to psychiatric care for Medicaid patients continues to be limited. In particular this is true for patients with intermediate level needs, as the focus has been placed on providing care for patients with the highest needs.
- The CCAR is not designed to assess and report progress on behavioral health issues that are typically addressed in the primary care setting. Further, the lengthy CCAR, in combination with other requirements to "open" a case with the BHO, is not compatible with the fast pace of the primary care setting, where increasingly behavioral health providers are utilized to assist with brief interventions in the exam room. Generally in the primary care setting, patients are "enrolled" indefinitely and may receive care across their lifespan without regard to acuity or diagnosis, and at CHCs, even as their insurance status moves from Medicaid, to uninsured or commercially insured.
- The requirement that CMHCs ensure co-location at high volume practices needs to be reviewed for compliance and enforced.
- There is a lack of clarity on the intended relationships between BHOs and RCCOs, so these relationships vary greatly depending upon the region.
- The rules and regulations of the BHO system are cumbersome in integrated care settings, creating barriers to creative integration opportunities. Additionally, for behavioral and medical care to become more integrated, incentives need to be aligned for both sets of providers.
- PCMPs contributing to positive care outcomes and cost avoidance on the BHO side of Medicaid have no ability to share in the savings generated.

5) **What is working well with RCCO and BHO collaboration right now?**

Discussions about how RCCOs and BHOs can consolidate in the RCCO rebid have begun.

6) **What is not working well with RCCO and BHO collaboration right now?**

Without a specific requirement to collaborate, integration seems to be a locally driven effort and appears minimal at this point.

Behavioral Health Integration

7) **What should be the next steps in behavioral health integration in Colorado?**[1]

Central to successful behavioral health integration is the integration of funding. The RCCO rebid process is an opportunity to begin developing alternative payment structures. Blended RCCO and BHO funding will likely lead to the best patient care.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	Barrier? No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	Carving out behavioral health funding creates silos which are an inherent barrier to integration.
Community Behavioral Health Services Rule	☒	☐	Rule places too much emphasis on providing high level care. To encourage preventative care and early intervention it should authorize receiving care through patient chosen providers, including PCMPs.
Covered diagnoses list	☒	☐	Too focused on severe and persistently mentally ill
Different behavioral / physical health reimbursement	☒	☐	This creates different systems of service with different outcome measures and objectives.
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	The CCAR is overly burdensome in primary care settings. The requirement to license substance abuse providers and facilities (vs. just providers as in other areas of behavioral health) creates a burden for primary care providers that could otherwise expand SA services on site.
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☒	PMPM itself is not a barrier, but the amount can be if it does not sufficiently cover expenses of required services.
Physical space constraints	☐	☒	
Privacy Laws (HIPAA, 42 CFR)	☒	☐	The complexity of 42 CFR in particular is a barrier, including over application/mis-application of current rules.
Professional / cultural divisions	☒	☐	CHCs providing onsite, integrated care have found that many behavioral health professionals need additional training to function in team based care models. Moving from the intensity of counseling sessions to brief interventions and opening and closing cases based on strict criteria to providing a broader range of

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

		behavioral health (vs. mental health) interventions is challenge for BH professionals new to the primary care setting.
RCCO or BHO contracts	☒	☐ The different payment models in each contract create natural barriers
Staff capacity	☒	☐ CHCs face recruitment challenges for qualified staff.
State/Federal rules or reporting requirements	☒	☐ The narrow definition of behavioral health providers that are billable to a BHO create difficulty when partnership with CMHC is not possible.
Technical resources / data sharing	☒	☐ Data sharing between disparate EHRs is currently cost prohibitive and is a limitation throughout the industry. The business drivers for an integrated model don't currently generate enough revenue to justify the cost of effective data sharing.
Training	☒	☐ Training on how to work as a member of an integrated team is not readily available, so integrated practices are recruiting from a narrow group of behavioral health providers who already have the needed experience.
Others		

9) **What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?**

The state needs to maintain consistency between the ACC expectation regarding integration and what is contained in the State Innovation Model (SIM) proposal presented to CMS. Of particular importance in the SIM proposal is the expectation that integrated care requires integrated, on-site teams of behavioral and physical health clinicians working on a unified care plan. Additionally, medication management, integrated health records, and providing for the majority of a member's comprehensive primary, preventive and sick care is necessary for a practice to be integrated.

It is also worth noting, that without the inclusion of oral health care, true whole-person/whole-family care is not achieved. Across the state CHCs are demonstrating how it is possible to care for the whole person through our focus on all three elements: physical, behavioral and oral health. While not every clinic is providing all services on site, they are all committed (and federally required) to address the needs of their patients in a comprehensive way through service provision and community partnerships.

10) **Please share any other general advice or suggestions you may have about behavioral health integration.**

Integration of funding in Medicaid for behavioral and physical health is required to make primary, preventative and behavioral health services more efficient and patient centered. Money should follow the patient – if a patient receives his/her mental health care at a CHC, the CHC should be able to bill HCPF directly for those services. Payment systems and contracts for behavioral and physical health should reimburse for preventative efforts.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

The Safety Net Medical Home Initiative (SNMHI) provides the most comprehensive definition of care management, and the National Committee for Quality Assurance (NCQA) provides the most comprehensive tool to measure the implementation of care management in a practice.

SNMHI defines the key charges of care coordination as: linking patients with community resources to facilitate referrals and respond to social service needs; integrate behavioral health and specialty care into care delivery through co-location or referral agreements; track and support patients when they obtain services outside the practice; follow-up with patients within a few days of emergency room visit or hospital discharge; and communicate test results and care plans to patients/families.

NCQA's assessment of a provider's care coordination and care transition system focus on three elements: test tracking and follow-up; referral tracking and follow up; and coordinating care transitions. The specific elements outlined in these three areas provide a comprehensive image of whether the organization providing care coordination has the procedures and mechanisms in place to provide the care as defined by SNMHI.

b. How should RCCOs prioritize who receives care coordination first?

RCCOs are currently maturing their ability to create intervention strategies with their populations. It should be up to the clinical leadership teams within the RCCO partnerships to decide how to best intervene with the members in their community.

c. How should RCCOs identify clients and families who need care coordination?

The RCCO clinical leadership teams should be responsible for creating care coordination strategies based on the priorities of the program, available resources and the needs of their communities.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

PCMPs and RCCOs should work together to develop systems for identifying those most in need of care coordination supports.

12) What services should be coordinated and are there services that should not be a part of care coordination?

No service should be explicitly excluded from care coordination, though there are several areas that require further development including:

- Pharmaceutical care coordination has primarily been focused on punitive measures that identify abuse in the system. Incorporating medication management more fully into care coordination will address those concerns while also reaching patients in need of further support with their medication.

- Communication between specialist and primary care providers needs improvement: Completing the communication loop between the PCMP and specialist is necessary to ensure that care coordinators have full information on patient needs and an up to date care plan.
- Reducing use of emergency room care for non-emergent needs continues to be a focus to reduce costs in health care, but not all regions have built systems that allow care coordinators to know when a patient has presented in the emergency room so follow up can be completed. Additionally, hospital systems tend to focus on what is needed to discharge a patient, not on connecting with providers who will continue care after discharge. Focusing on the relationship between PCMP and RCCO care coordinators and hospital systems will help address both of these issues.

13) **What pieces of information are most important to have about someone in order to know what care coordination he or she needs?**

Psychosocial information such as where the patient lives, with whom the patient lives, and what resources he or she has are key to understanding what kind of care coordination he or she needs. While access to the patient's medical and behavioral health records are also essential, these often do not include the information that needs to be a part of the patient record for successful care management. CCMCN is currently configuring an enterprise care coordination software application intended to be used by the community. In order for the application to be a valued community resource, we are identifying the necessary data elements to import from the practice EHR, from claims and from the hospitals via HIE.

14) **Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.**

a. **What care coordination is going on today?**

Care coordination today is either disease specific or event driven, such as when a hospital discharge occurs. Patients with disease specific care coordination may have more than one care coordinator within the same health system. Ideally care coordinators are integrated into the care team, across diseases or issues.

b. **What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?**

Different organizations have coordinators dealing with different issues (i.e. housing, food access, etc.) whom may also be dealing with health care issues. The work being done by those organizations may have profound impacts on the health of a patient, but if a relationship is not present between the PCMP and the outside organization there is no way to identify those potential impact areas. To address this issue there may be a role for RCCOs in convening coordinators across communities to increase communication and reduce duplication. Our solution for this is by providing a shared community care coordination software application.

c. **How can the ACC avoid duplicating or disrupting current care coordination relationships?**

It is important to recognize that care coordination is often done by individuals with a variety of titles and training, such as Transition Coordinator, Promotoras, and Case Managers. In exploring what is already in place in a community it is important to focus on their functions and measurable outcomes.

d. What are the gaps in care coordination across the continuum of care?

Care coordinators need access to real-time patient care event data, outcomes and cost information in order to providing meaningful care coordination. We are currently building more sophisticated and integrated data systems to accomplish this.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

The areas identified in the table below are functions that the organization providing care coordination should be providing. Across the state, CHCs have care delegation agreements with RCCOs and in those situations the responsibility for coordinating with community supports and services on these issues would typically be delegated along with other responsibilities to the PCMP. In instances in which the RCCO is providing the care management (no care delegation in place, non-attributed patient, or patients attributed to PCMPs without a delegation agreement), the RCCO does have the responsibility for coordinating on each of these issues as needed within the region. The RCCO should have the responsibility for whole person care and the RCCO has the ability to delegate the responsibility to the PCMP or other organization as appropriate. The RCCO or delegated agency will need the financial resources to be able to provide this level of support.

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☐	See narrative above for this table
Affordability (assistance with prescriptions or co-pays)	☒	☐	☐	
Daycare / childcare	☒	☐	☐	
Economic stability & employment	☒	☐	☐	
Education	☒	☐	☐	
Environment	☒	☐	☐	
Food access /	☒	☐	☐	

nutrition				
Health literacy	☒	☐	☐	
Housing	☒	☐	☐	
Language or translation services	☒	☐	☐	
Literacy	☒	☐	☐	
Transportation	☒	☐	☐	
Other				

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Care coordination models should be directed by the clinician leadership that exists within each RCCO. Focus should be placed on the outcomes desired and on the resources available to provide support. RCCOs and PCMPs with care coordination delegation should have the flexibility to create a system that works for their population in achieving those outcomes.

Type:	**Coordinate care?** Yes	No	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☐	☐	See narrative above for this table
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family	☐	☐	

Therapist			
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other			

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

The clinical leadership within each RCCO can develop the intervention strategies that maximize the impact with all available resources.

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	See narrative above for this table
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral	☐	☐	

health diagnosis or substance use disorder			
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) **How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?**

RCCOs should work with existing resources to understand the best approach for their community.

19) **How should care coordination be evaluated? How should its outcomes be measured?**

It's the RCCO's responsibility to create relevant metrics for evaluating the effectiveness of their care coordination strategy. Strategies will likely be different between RCCOs. Clinical leaders within each RCCO should choose short and long term intervention strategies for their populations and measuring the effectiveness of care coordination is only a piece of the strategy.

20) **Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.**

   a. **What is the PMPM cost for providing care coordination services?**

The cost of providing care coordination services varies depending on a number of factors, including volume of clients, the complexity of their needs, economies of scale by centralizing resources and the clinical intervention strategy established by the RCCO.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

Possibly, if it can be based on an estimate of touches that drive the care coordinators work load. A population that requires more interaction will be more expensive because the care coordinators panel sizes will need to be smaller.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

The next RFP could require that the RCCOs come up with intervention strategies and care coordination panel sizes but because every RCCOs strategy could be different, these requirements shouldn't be defined outside of the RCCO. The clinical leaders within each RCCO are in the best position to define an expected number of members that can be managed by the care coordination teams. RCCOs and PCMPs with care coordination delegation should have the flexibility to create strategies that work for their population.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

The Department should choose metrics that are of highest value to the Department to know and leave the operational metrics up to the RCCOs to define the best intervention strategies and metrics for their region. It will be up to the RCCO to ensure that their intervention strategies are aligned with the metrics that are important to the Department. The Department should evaluate the effectiveness and outcomes of the RCCOs and the RCCOs can be responsible for evaluating their own care coordination strategies.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Creating new, innovative and data driven approaches to care coordination is going to be one of the key elements of a successful Medicaid population health and cost strategy in Colorado. The Department will need to empower the RCCOs by holding them accountable for developing, implementing and measuring these strategies.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

The following functions could be standardized across RCCOs:

- A population health and cost strategy could be required to be submitted by all RCCOs
- Reporting from the Department about the effectiveness of the RCCOs should be standardized
- PCMPs could be required to be using an HIE, making progress on Meaningful Use and PCMH to be eligible for PMPM payments
- Referral protocols - currently the referral protocols submitted by the RCCOs are highly variable
- As the state moves forward with payment reform, consistency will be needed in how providers are paid

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

The RFP could require applicants to include letters of support from community organizations, safety-net providers and hospitals. To evaluate the strength of those relationships, applicants could include information on the length and extent of their relationship with those partners. Additionally, a clear plan for or explanation of their community engagement process could be included, contain what community meetings are attended and the RCCOs advisory committee structure.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

Large PCMPS with sites in multiple regions should be able to select a single RCCO that holds the majority of their members. Working with multiple RCCOs creates administrative complexities and presents barriers to future innovations to improve patient centered care, particularly around payment reform.

RCCOs themselves are very diverse organizations with different approaches to payment reform, referral processes, care coordination, and willingness to partner on innovative approaches to care. When working with multiple RCCOs, PCMPs are faced with challenges as simple as the time commitment required to attend multiple meetings on similar topics, to the difficulties of aligning systems, including billing systems should the RCCOs become a payer. Being able to work with a single RCCO would eliminate the complexities and allow large provider systems to work more closely with that RCCO to identify areas for improvement and innovation.

We recognize that this is a departure from the way the program is currently structured and there are several considerations that will need to be discussed. One of the original principles of the regional distribution was the equitable distribution of lives, so the issue to consider now is if with the increased number of patients covered whether equitable distribution is still necessary to the success of the program. A second area to consider is attribution. There would need to be a mechanism in place to ensure that RCCOs attribute to providers within their region, even if they are not the CHC-designated RCCO the provider is working with. Additionally,

attribution to RCCOs is currently done based on the patient, so the criteria for how large provider systems would be attributed to a RCCO have not been established.

27) **Should the RCCO region maps change? Why or why not? If so, how?**

Regions should reflect the natural referral pattems and clinical appropriateness rather than administrative simplicity concerns. As an example, Larimer and Weld counties have a lot of overlap between providers, hospital systems, and referral pattems between Loveland, Greeley and Fort Collins, yet are divided between RCCOs. These divisions may not have an impact on referral pattems or access to care currently, but as RCCOs develop medical neighborhoods they could increasingly become an issue.

In addition to the example above regarding community referral patterns, the division of natural communities, such as metro areas, creates difficulties in establishing community relationships and partnerships. For example, the Denver metro area is divided between three RCCO regions. Two of those regions share an administrative organization, but with the patient population served by Medicaid it is a recurring issue that patients move, and in doing so change RCCOs which creates communication issues.

The RCCO region map could be evaluated based on the concems of providers in those regions. Another consideration is to combine regions for organizations that hold the contracts for multiple regions.

28) **Should the BHO region maps change? Why or why not? If so, how?**

If the Department's motivation is to combine the BHOs and the RCCOs, matching the regional boundaries could be helpful. Behavioral and physical health cannot be fully integrated until payment systems are integrated, so alignment of regions is a logical first step to integration of care.

29) **Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?**

The required time for successful transition will largely depend on the structure of the new vendor. If the vendor selected is currently serving as a RCCO in a different region, the transition should take less than three months as attention can focus on changes to contracts with providers and care coordination delegation. If the organization is a new RCCO contractor without systems in place, it will take at least six months to establish both IT systems and the contracts with providers and care coordination organizations, but many these activities can occur prior to the start of the next contract period.

30) **What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?**

In order for patient designated attribution to work better, Health*Colorado*'s contract should include the following:

- Funding and accountability to assure efficient and accurate patient designated attribution.
- The ability for clients to designated their PCMP on the Medicaid application, both on paper and through PEAK.

- Ability for all Medicaid clients, new and those previously enrolled, to submit PCMP selection and changes through a fax or online form which receives a confirmation receipt for both the patient and selected PCMP.
- Appropriate call center staffing levels to minimize wait times to under 5 minutes and a system implemented which allows patients to leave a number and be called back by a representative rather than remaining on hold.
- If a patient does not select a PCMP after a designated time period, auto attribution to a narrow group of high volume, high quality providers is implemented. Screening criteria for eligible providers should include items such as: practice open to new Medicaid patients, practices with delegated care coordination agreements with the RCCO, practices with national Patient Centered Medical Home recognition or other similar standards, practices with electronic medical records capable of running reports for patient population health management and quality improvement, and practices contracted with CORHIO.

In addition to the changes to the Health*Colorodo* contract regarding attribution, HCPF should implement policy in which providers that can demonstrate having served as the PCMP between enrollment and attribution receive retroactive PMPM payment.

The following waivers or SPAs should be sought from CMS:

- Waiver to allow patient assignment or lock in to providers. This will be necessary to move forward with payment reform because providers cannot be held responsible for managing patient health outcomes if the patient does not have an obligation to utilize the assigned provider.
- SPA to utilize projected annual income for Medicaid determination.
- Waiver to allow 12 months continuous eligibility for adults in order to address issues of churn.
- SPA for alternative payment mechanism for CHC payment once the methodology is developed and agreed to.

31) **What are the limitations of the current benefit structure and what – if any – changes are needed?**

The two primary limitations that need changes are regarding the cap on dental services for adults and case management restrictions.

- The need for dental care exceeds the $1,000 cap and is limiting the ability of providers to provide high quality care in an efficient time frame in order to reduce further cost implications in the future. If patients cannot afford to continue treatment after the cap the state risks those needs elevating from a simple dental procedure to an emergency room case.
- Case management is not included in the benefit structure, though it is provided by CHCs and reduces the overall cost of care. Adding case management to covered benefits would allow expansion of the service, ultimately decreasing the overall cost of caring for the population.

Additionally, the current benefit structure does not incentivize patients to utilize less expensive, more appropriate care settings. A lot can be accomplished through providers and care coordinators, but structuring the benefit to further incentivize patient choice would further these efforts.

32) **Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?**

No, PCMPs have already experienced the complications of working with multiple RCCOs and expanding the number per region would only accentuate the problem. Additionally, multiple RCCOs per region adds a degree of complexity to not only the provider level, but processes such as attribution.

33) **If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?**

All CHCs are Medicaid providers.

34) **What role should RCCOs play in attributing clients to their respective PCMPs?**

RCCOs should be responsible for ensuring that everyone selects a PCMP within the first three months of enrollment.

35) **What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?**

The Department of Public Health and Environment (CDPHE) already tracks many population level health trends which would be of use to the ACC Program. Likewise, information gathered regarding the Medicaid population through the ACC would be beneficial to CDPHE in expanding their data set. Additionally, CDPHE tracks data regarding emerging public health issues which would be beneficial to share in a timely fashion with providers, and providers could be a useful resource to CDPHE in responding to emergency situations. Collaboration around bi-directional data sharing should be built for the benefit of both programs.

36) **What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?**

The ACC and DHS should, at a minimum, compare goals to ensure alignment. This would be accomplished best at the Governor's Cabinet level.

37) **What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?**

The two programs should align eligibility determination methodology. For example, the two should align income requirements to annual income projections, and Medicaid adults should receive 12 months continuous eligibility. Aligning these two elements will reduce chum between the programs and increase consistency of care for patients.

Until the necessary alignments can be accomplished, Connect for Health Colorado and the ACC Program should work closely to ensure that patients whose eligibility changes and movement between the programs is necessary have consistent access to primary care.

38) **What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?**

The DOI should be an active participant in payment reform discussions and evaluation of models if the RCCO are anticipated to move into risk.

Stakeholder Engagement

39) **What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?**

Defining a stakeholder engagement strategy should be the responsibility of the RCCO leadership teams because regional strategies will vary based on the population and available resources.

40) **What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?**

It could be an expectation that the RCCO become integrated and aligned with all appropriate community resources.

41) **Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?**

See response to question 40.

42) **How should the Department structure stakeholder engagement for the ACC as a whole?**

The Department should continue to host regional stakeholders meetings.

Network Adequacy and Creating a Comprehensive System of Care

43) **Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?**
   a. **If no, what are the gaps?**
   b. **Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.**

A large part of the problem with accessing care is the lack of providers accepting Medicaid, and part of that is due to the lack of incentives for hospitals and specialists to engage patients and respond to the population needs. RCCOs should have the flexibility and the charge to work with providers in their regions to develop these incentives.

44) **ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.**

   a. **What role should hospitals play in the next iteration of the ACC Program?**

Hospital care coordinators can be better integrated with RCCO care coordination staff. If RCCOs move toward shared savings and risk contracts, it will be important to bring the hospitals into the conversation in a meaningful way.

   b. **What role should pharmacies play in the next iteration of the ACC Program?**

Pharmacy is an area that could be increased in care coordination work. Pharmacists can be contributing to care coordination through medicine reconciliation for patients and working with care coordinators to educate patients.

   c. **What role should specialists play in the next iteration of the ACC Program?**

As RCCOs start to tune their ability to create more efficient community systems, they will want to create more efficient referral and care coordination systems with specialists.

   d. **What role should home health play in the next iteration of the ACC Program?**

RCCOs should be required to create a care transition system that includes specialists, hospitals, pharmacies, home health, hospice and PCMPs. The patient would greatly benefit from each of these organizations using a shared care coordination platform.

   e. **What role should hospice care play in the next iteration of the ACC Program?**

RCCOs should be required to create a care transition system that includes specialists, hospitals, pharmacies, home health, hospice and PCMPs. The patient would greatly benefit from each of these organizations using a shared care coordination platform.

f. **What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?**

RCCOs could consider having community advisory boards which include representation from SEPs, CCBs, counties, local public health agencies, and other community health organizations and nonprofits.

g. **What role should counties play in the next iteration of the ACC Program?**

RCCOs could consider having community advisory boards which include representation from SEPs, CCBs, counties, local public health agencies, and other community organizations and nonprofits.

h. **What role should local public health agencies play in the next iteration of the ACC Program?**

Public health could be instrumental in developing data driven population health interventions.

i. **What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?**

How to best align the RCCO with community non-profits should be the decision of the RCCO leadership teams. Colorado is fortunate to have a sophisticated network of healthcare non-profits that are ready and willing to align with the RCCO program.

45) **How can RCCOs help to support clients and families in making and keeping appointments?**

RCCOs should work with their delegated practices on how to partner around no shows. If needed, RCCOs could support PCMPs in implementing practice level interventions, such as implementing recall or appointment reminder systems, through technical and financial support.

46) **Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?**

The functions described should be included in each region's care coordination approach, but the specifics of job titles and the mix of providers should not be prescriptive. Community Health Workers are most effective at the PCMP level within the community, so it should be an option for PCMPs and organizations with care coordination delegation but it should not be a requirement. The focus should be on developing locally appropriate systems that fulfil the functions and meet identified outcomes.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

All options could be viable options for reimbursing for the work done by Community Health Workers, but see question 46 for thoughts on the appropriate level for utilizing these workers.

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☒
On staff (salary) at RCCO	☒
Per Member Per Month Payment	☒

48) **Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?**

Since the RCCOs are more locally focused and have established relationships in the community, they would be a good partner for the ASO to utilize in establishing those local relationships and identifying providers.

Resources permitting, RCCO care coordinators could include oral health and accessing dental services in their efforts to get patients appropriate and timely care. Additionally, RCCO care coordinators could be providing encouragement and education to patients about the importance of regular, preventative oral health care.

49) **Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.**

a. **What does cultural competence mean to you?**

The National Committee for Quality Assurance define cultural competency as not only having empathy, but expressing it towards patients regardless of the patient or provider's cultural background. In order to do so, clinical and non-clinical staff must have an adequate understanding of their patient population including its diversity, health literacy, language needs, etc. With understanding of the patient population, providers are encouraged to utilize motivational interviewing as a technique to facilitate culturally competent conversations.

b. **What RCCO requirements would ensure cultural competency?**

All clinical staff could be trained in motivational interviewing and enroll in cultural competency trainings with continual follow up, both of which RCCOs can provide or facilitate connections to. RCCOs could also require practices to determine cultural competency standards and hold them accountable for meeting training all staff about and meeting those standards.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all clients/families including those with low health literacy?

See response to b.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Bilingual or translation services, on-site staff with expertise in cultural competency, and ensuring that every patient completes a health literacy assessment are factors that contribute to enhanced cultural competency. Skills learned during trainings would incorporate the ability to refrain from making assumptions and would ideally educate participants on what it means to have implicit and explicit biases.

50) **Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?**

Preferred networks help manage population health and generally help reduce waste in the continuum of care, but without movement towards payment reform RCCOs will not have the ability to develop or enforce these networks.

If payment reform options with any element of risk, even if only partial, are to be considered in the next RFP, networks of preferred specialist, facility and ancillary providers must be allowed. The development of these networks will need to be coupled with enhanced prior authorization processes to allow RCCOs and PCMPs to reduce total costs, improve outcomes and improve patient care.

51) **Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?**

At the patient level the ACC could evaluate options for slight changes to patient co-pays which could create disincentives for frequent and inappropriate use of emergency rooms, particularly where other care options are available. Additionally, not all hospitals are actively participating in ACC. A combined effort by RCCOs and the state should build additional mechanisms into the ACC which will engage more hospitals.

At the regional level, RCCOs should be developing community diversion strategies where one is not in place. Partnerships between PCMPs and hospitals have been highly successful in redirecting patients to primary care

when more appropriate and making that care available, and RCCOs could be bringing community partners to the table to begin these discussions.

52) **Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.**

The specialist network for Medicaid patients is highly limited. RCCOs could have the resources to develop incentives to encourage specialist and hospital participation.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

A high functioning RCCO should be able to provide all of these supports as needed to practices, though it should be recognized that not all practices will need these supports and therefore none should be tied to a specific tool. As PCMPs who have care management delegated, our members have most of these elements in place, and requiring a specific tool would require additional administrative work to utilize both the PCMPs process and the RCCOs, and would likely require financial investments to incorporate a duplicative function.

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☒	☐	☐	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☒	☐	☐	☐
Provide registries	☒	☐	☐	☐
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☒	☐	☐	☐
Supply behavioral health surveys	☒	☐	☐	☐
Supply other self-screening tools	☒	☐	☐	☐
Administer behavioral health surveys	☒	☐	☐	☐
Administer other self-screening tools	☒	☐	☐	☐
Prepare client action plans	☒	☐	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☒	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☒	☐	☐	☐
Provide standing pharmacy order templates	☒	☐	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☐

Provide directory of other resources	☒	☐	☐	☐
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others				

54) **If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.**

No specific tool should be required but using centrally managed tools could be encouraged. Smaller practices and those without care delegation may need higher levels of support, but practices that have care management delegation and existing processes in place should not have to change tools or duplicate work and financial investments to meet a RCCO specific requirement. In particular for situations in which providers serve patients from multiple RCCOs, requirements of specific tools would create additional barriers to providing patient focused and cost effective care. Because PCMPs don't see 100% Medicaid patients, providers can't be expected to use tools designated for only specific payer populations. Tools provided to the providers should be intended for their entire population.

55) **What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?**

Assuming that the financial resources exist, RCCOs should provide technical support as requested by practices. Practices that are already engaged in medical home efforts should be able to evaluate their practice's needs and drive the support needed from the RCCO in addressing those areas.

56) **What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?**

Established national standards, such as the National Committee for Quality Assurance's Patient-Centered Medical Home Recognition, are the most effective way to recognize a PCMP's capacity to service as a medical home for patients. These standards set expectations of what is expected of a medical home that are consistent regardless of the region and have an established process for recognition.

Practices could be compensated for their level of recognition through these national standards, with practices incentivized to improve their rate because it is tied to increased PMPM or capitation payments.

57) **Should the Department require that PCMPs utilize disease registries to manage the health of their population?**

All PCMPs should utilize a registry or electronic medical record that has the capability of running reports for population health management and quality improvement as that is the standard of care.

58) **Please share any other advice or suggestions about provider support in the ACC.**

High performing PCMPs need to be rewarded based on their performance. Currently in the ACC recognition is primarily at a regional level, which does not encourage further development of those high performing practices. RCCOs should be required to report and reward individual practices.

Payment Structure and Quality Monitoring

S9) **Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?**

No, the current payment structure is still paying for volume, not quality. As discussed in response to question 58, providers are not being rewarded or tracked by their own individual performance which is not providing incentives to low performers to improve or for high performers to continue to develop. Additionally, as discussed in response to questions 4, 43, and 52 there is no incentive for specialists to participate and engage with patients in a meaningful way.

The Shared Savings component of the ACC is particular limited in its ability to recognize and reward high performers – many measures can only be attributed to the region, which may result in a high performer being left out of payments due to poor performance by providers elsewhere in the region. The size and geographic diversity of many of the regions prevent meaningful coordination and care improvements between providers.

60) **If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?**

CHCs are interested in working with HCPF to develop and pilot an Alternative Payment Methodology (APM) that moves away from FFS and towards population-based payment. Many CHCs are interested in taking on additional risk over time. Other states are piloting converting the PPS rate into a PMPM for primary care.

In a capitated payment structure, the initial PCMP cap should include physician services, non-E&M PCP services, and OP Labs/Pathology as these are services primarily handled by PCMPs. In later years the program could begin to expand into additional services, such as diagnostic imaging, PT/OT/ST, DME (with agreed upon carve outs), and OP Radiology (professional services only). Ideally all three elements of integrated, whole person care (physical, behavioral, and oral health) would be included.

61) **Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?**

CHCs as providers do have the infrastructure to support value based payments, however additional resources would be needed to add expertise at the State and RCCO level for rate setting. Without rate setting expertise and third party validation, CHCs cannot risk PPS/APM and expect to remain viable.

62) **The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?**

There are models utilized, both partial risk and capitation, which do not require a DOI license if sufficient reserves are held. The Department should evaluate options for payment reform models which do and don't require DOI licensure and decide which approach is best for the Department. The need for risk based capital reserves will require partnerships with potentially new organizations that have the ability to financially back the risk. Knowing the Departments position and timing on allowing risk contracts that require reserves will be very helpful as we prepare for the rebid.

63) **What role – if any – should the RCCOs play in the distribution of payments to providers?**

For CHCs, it may make sense for the state to remain the payer to resolve the potential of large PCMP systems being subject to different payment pilots or methodologies in each region where they have patients. This could also be resolved by allowing PCMPs to choose a single RCCO. Regardless of the direction taken, all parties involved (CHCs, RCCOs and the state) will need to work together closely to determine the appropriate role of the RCCO in payment distribution.

64) **Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.**

High performing PCMPs are not currently incentivized to continue to improve their practice, a concern that payment reform needs to take into account. Providers who are responsible for care improvement and cost savings should be rewarded with shared savings and incentive payments.

The vision of RCCOs is to increase system effectiveness, but the care and decisions made regarding payment and practice reform most greatly impact the PCMP. To address this negotiations regarding payment reform need to be with the PCMP providers with RCCOs as a partner.

65) **What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?**

Measurements such as clinical data on behavioral health, oral health, chronic and acute care services, unhealthy behavior, and factors that contribute to care such as social determinants of health and assessment of health literacy could be used to measure impact.

66) **Measuring Client experience**. Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	The full CAHPS survey is composed of 52 questions and the administration of it in entirety is felt to be too administratively difficult to implement. CHCs did agree to utilize and report on 5 questions from CAHPS, and we would advocate considering this shortened version to evaluate patient satisfaction: 1. In the last 12 months, how many days did you usually have to wait for an appointment when you needed care right away? (a. Same day, b. 1 day, c. 2 to 3 days, d. 4 to 7 days, e. More than 7 days) 2. In the last 12 months, how often did this provider explain things in a way that was easy to understand? (a. Never, b. Sometimes, c. Usually, d. Always) 3. In the last 12 months, did anyone in this provider's office talk with you about specific goals for your health? (a. Yes, b. No) 4. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 12 months, did you see a specialist for a particular health problem? (a. Yes, b. No – if no, skip question 5) 5. In the last 12 months, how often did your provider seem informed and up-to-date about the care you got from specialists? (a. Never, b. Sometimes, c. Usually, d. Always)
SF-12 Health Survey	☒	☐	This tool is not used by CHCs at this time, so while we have no objection to it being an option, it should not be the only tool available.
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☐	☒	The tool is not used for patient satisfaction, primarily a patient education tool
Focus groups	☒	☐	
Other	The state could focus on patient satisfaction tools, not patient education tools. Additionally, as referenced in other questions, tools should not be prescriptive and requiring practices to implement duplicative efforts.		

67) **Knowing that, at this time, the Department only has claims data, how should population health be measured?**

The Department should look beyond claims data to other partnerships that could be provided to develop data on population health, in particular through partnership with the Colorado Department of Public Health and Environment (CDPHE). Claims data, lab and pharmacy data, CDPHE's health survey data, and outside data sources such as the Colorado Health Access Survey could be utilized to measure population health until more robust and timely data tracking and measurement tools are in place. CCMCN has a clinical data warehouse for the FQHCs that could easily be expanded to include other PCMP EHR data.

68) **How should quality and performance data be reported to the RCCOs, PCMPs, and the public?**

Quality and performance data should be reported to PCMPs consistently across RCCOs so that those who serve patients across multiple regions can better understand their impact on their patient population. Additionally, this data should be provided on a regular basis and should include comparison information demonstrating not only how the PCMP is performing in relation to itself, but also in relation to comparable practices and the region as a whole. Presenting comparison data is the only way to identify top performers and ways to learn from their system to achieve the triple aim.

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

Impact is difficult to be measured over time if the measures do not remain consistent. Ideally the Department would pick a small set of measures that are important to the Department to know and publish.

70) **What percent of RCCO payments should be tied to measures or performance?**

Percentage	
10-20%	☒
21-30%	☐

31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

It depends on the measure. The percentage should start low and be increased over the period of the contract as policies and reporting systems need to be established in order to tie payment to performance.

71) **Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?**

Yes, all regions should have the same KPIs, and RCCOs and providers should be working toward the same statewide goals.

72) **Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?**

Reimbursement should be based on progress toward meeting national standards, with ongoing rewards for those who meet or beat the standards. While it might be necessary to create incentives that are based on individual improvement to encourage movement towards national standards, payment systems should more heavily reward those that have meet and continue to beat national standards.

73) **Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.**

Yes

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

RCCO's should have a fixed percent for administrative costs.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

CHCs monitor and report performance publicly via the Uniform Data System and small amounts of funding are increasingly tied to quality payments, including:

- Performance in Medicare Advantage
- Meaningful Use has paid practices based on meeting quality outcomes with HIT PCMH attainment

CHCs are increasingly seeking and occasionally receiving reimbursement for performance on patient satisfaction, provider satisfaction, services and screening rates, and access and availability measures.

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other: As providers, CHCs find phone calls and face-to-face meetings to have the most success in communicating with patients. Some CHCs have begun to use text messages and all are working to get patients to use web portals.		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

CCMCN is heavily investing in data systems to support population health and cost management as well as care coordination and business intelligence systems.

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☒	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☒	☐
Practice assessment tools	☒	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☒	☐
Shared decision-making tools	☒	☐
Telemedicine software	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other

organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and S are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☐	☐	☒
Health risk assessment software	☐	☐	☐	☐	☒
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☒	☐
Patient education wellness tools	☐	☐	☐	☐	☒
Provider/case manager directory	☐	☐	☐	☐	☒
Shared decision-making tools	☐	☐	☐	☐	☒
Telemedicine	☐	☐	☐	☒	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Timely, updated and accurate information regarding care sought outside of a PCMPs practice are needed to be actionable for care transitions and it isn't currently available today. The lack of shared data systems is a barrier to this, but CCMCN and CORHIO are quickly developing solutions that should be utilized and encouraged.

81) How can Health Information Technology support Behavioral Health Integration?

CCMCN is currently implementing a community care coordination application that is intended to bring together all community resources into a shared record with shared care plans that cross between primary care and behavioral health. Leveraging a shared care coordination resource will naturally create integration. CORHIO has been able to develop mechanisms to bridge gaps between different systems in order to facilitate access to real time data. However, CORHIO is currently addressing the barriers related to sharing behavioral health information as the federal regulatory requirements on sharing this information are more burdensome. Changes are needed to the regulations that are preventing data sharing from behavioral health.

82) **In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.**

Possibly. The Department will certainly need its own data and analytics for internal operations but the RCCOs will also need tools as they build population health and cost strategies within their communities. If the RCCOs are moving into risk contracts, they will probably want the ability to choose their own tools to run their businesses.

83) **Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.**

Yes, but it needs to be payer agnostic and available for the entire community. The most effective tools to facilitate more coordinated care will receive clinical data from PCMP EHRs, admit and discharge data from hospitals and claims data so that it can create alerts and tasks based on predefined interventions.

84) **Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.**

Possibly. The Department will certainly need its own tools for internal operations but the RCCOs will also need tools as they build population health and cost strategies within their communities. If the RCCOs are moving into risk contracts, they will probably want the ability to choose their own tools to run their businesses.

85) **Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.**

A provider directory should be searchable by provider, site, and/or entity; contain information on if they are currently accepting new ACC enrollees; and contain accessibility information such as hours of operation and languages spoken. Additionally, the provider interface should have a way to easily update information, contain provider contact information, and contain information regarding making referrals to the practice. On the patient side it should also contain quality information about the provider.

86) **How can the RCCOs support providers' access to actionable and timely clinical data?**

Access to actionable data is a priority for data driven decision support. The RCCOs should be creating the infrastructure to get this functionality to the PCMPs as appropriate.

87) **What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.**

There are many HIT solutions which would provide benefits to clients, providers and RCCOs. Patient access to web portals to track their health information and direct messaging with providers would be useful in engaging patient in their health. Telemedicine, especially in relation to accessing specialists, would beneficial in

expanding access to care. Instant communication in the form of email or text when a patient presents in the ER would be beneficial to case managers.

In order for any of these to be utilized to the full extent of their possibilities, there needs to be a system in place for sharing data across systems. CCMCN and CORHIO are actively developing solutions that are intended to address the needs of the RCCOs.

88) **What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.**

The RCCOs could become a centralized vehicle for many kinds of technical assistance as long as they have enough financial resources to provide it.

89) **What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?**

The HIEs have an important role to play in successfully developing the systems which will allow real-time, clinical data to be shared, which is required to fully realize the benefits of care coordination. Colorado's HIEs are actively building solutions, so they should be included as a partner in these efforts.

90) **Please share any information, advice, and suggestions you have about health information technology in the ACC Program.**

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 097

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Kerry Cogan for CHPA
Location: Denver, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Community Health Provider Alliance
Location: Denver, Colorado
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☒ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☒ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:

The Community Health Provider Alliance (CHPA) is a statewide integrated accountable care network of Federally Qualified Community Health Centers (FQHCs or CHCs) in Colorado. CHCs are integral to the success of the ACC and provided a health care home for 28% of all Medicaid enrollees in 2013. CHCs helped launch the ACC by taking the first enrollees in 2011, and formed or serve in a governance role in several RCCOs. Several of CHPA's members have been active participants in the ACC performance improvement advisory committee (PIAC) and various subcommittees.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

See response above.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☒ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

The ACC is a positive step towards improving care coordination, allows for innovation and flexibility within regions, and establishes more accountability for improved outcomes. Specifically, the benefits of the ACC include:

- Care management financial support has brought much needed care coordination efforts to high risk populations.
- Improved partnerships with local hospitals and community partners in some regions, particularly with focused alignment around the Key Performance Indicators (KPIs).
- Medicaid, RCCOs and PCMPs are engaged and focused on improving outcomes and containing healthcare costs.
- More focus on implementing payment reform that values outcomes versus output with innovative models being piloted that may expand to additional regions/providers.

2) What is not working well in the ACC Program?

While the ACC has led to some improvements in care, there are a number of areas in need of further development.

- Attribution:
    - Too many Medicaid enrollees remain unattributed to a PCMP for too long, decreasing the ability of PCMPs to engage patients and begin implementing interventions to improve outcomes and contain costs. While monthly attribution has addressed some of these concerns, the ACC program should move to auto-assignment for those that remain unattributed after attempts have been made to have them select a PCMP. See question 30 for specific recommendations about auto assignment.
    - The process to change PCMP attribution is too burdensome on the patient, and as a result some providers serve as a patient's PCMP without the recognition and financial support provided by accurate attribution. This process needs to be refined to allow patients to change PCMPs in a timely fashion.
- Timely and accurate data is central to a provider's ability to successfully manage population health and make adjustments to improve outcomes. Current data provided to PCMPs is not timely, not actionable, and not presented in a way that allows providers to validate that their data is accurately represented. Additionally, data provided varies by RCCO and therefore cannot be aggregated across regions, preventing PCMPs serving patients from multiple RCCOs to accurately understand their performance. Specific recommendations regarding data are included throughout this response, but in particular see the Program Structure and Health Information Technology sections.
- RCCO and PCMP relationships vary by region and present challenges for large PCMP systems located in multiple regions. These large PCMPs often find themselves stretched between differing requests and requirements, and varying priorities and strategies which are not always coherent. In one example, a CHC serving multiple RCCOs was able to launch a diabetes intervention program in one region with a RCCO, but not another, which resulted in participation being dictated by the county the patient lived in even when they utilized the same clinic and saw the same provider. In addition to increased

standardization of expectations across RCCOs, RCCOs need to be held to a high standard of engaging PCMPs in discussions that will impact clinical practice or reimbursement. See Program Structure section for specific recommendations.

- The ACC program should require more transparency from RCCOs in governance, operations and financing to be assured that there are adequate dollars going to impact care and provide support to providers.
- Hospitals must play a significant role in the ACC to achieve the desired outcomes of better health care and healthier patients at a lower cost, but there are not enough incentives currently to participate, nor disincentives for not participating in these efforts. Isolated, local relationships may be strong enough to create some impact in a single community, but incentives are lacking in the current ACC and should be included in the next iteration.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

Similar to the ACC, CHCs have seen both areas of success with the BHO system and areas in need of significant change. A few successes to highlight:

- Access to behavioral health care is expanding in some areas as Community Mental Health Centers (CMHCs) are hiring staff and working to meet the increased demand created by Medicaid expansion.
- Partnerships between CMHCs and CHCs are very strong in some areas, resulting in improved access to behavioral health services through the integration of CMHC staff into CHC care teams, and in a few places, improved access to primary care by bringing CHC staff to the CMHC.
- The launch of the statewide crisis response system is filling a gap and providing a service that was not available in the state before now.

4) What is not working well in the BHO system?

Overall, the focus of the BHO program on covered diagnosis and procedures does little to support integration in the primary care setting, where the behavioral health needs of patients don't always fall neatly into a diagnosis. PCMPs are ideally situated for providing preventative care and early interventions, but PCMPs must navigate complicated and varied CMHC/BHO relationships and billing procedures to receive payment for this care. Access to behavioral health care for Medicaid patients seems to be improving where there have been issues, but continues to vary by community and region and is overly dependent on local contractual relationships.

The separation of funding for behavioral health care from medical health care, does not allow for the alignment of incentives to improve care. Integrating the funds for medical and behavioral care (e.g. ending the carve-out) will make both service provision and access to care more efficient and patient centric. Money should follow the patient, meaning if a patient receives their behavioral health care at a CHC, the CHC should be able to bill a single entity for care. In addition to the need to integrate funding, the following issues need to be addressed:

- Access to psychiatric care for Medicaid patients continues to be highly limited. In particular this is true for patients with intermediate level needs, as the focus has been placed on providing care for patients with the highest needs. Additionally, to increase access to care, the following need to be included as

performance measures: wait time for an appointment, underutilization monitored by comparing disease prevalence rates to penetration rates, and network/provider experience reporting.

- The CCAR is not designed to assess and report progress on behavioral health issues that are typically addressed in the primary care setting. Further, the lengthy CCAR, in combination with other requirements to "open" a case with the BHO, is not compatible with the fast pace of the primary care setting, where increasingly behavioral health providers are utilized to assist with brief interventions in the exam room. Generally in the primary care setting, patients are "enrolled" indefinitely and may receive care across their lifespan without regard to acuity or diagnosis, and at CHCs, even as their insurance status moves from Medicaid, to uninsured or commercially insured.
- The requirement that CMHCs ensure co-location at high volume practices needs to be reviewed for compliance and enforced.
- There is no clarity or direction on the intended relationships between BHOs and RCCOs, so these relationships vary greatly depending upon the region.
- The rules and regulations of the BHO system are cumbersome in integrated care settings, providing reasons to resist creative integration opportunities. Additionally, for behavioral and medical care to become more integrated, incentives need to be aligned for both sets of providers.
- PCMPs contributing to positive care outcomes and cost avoidance on the BHO side of Medicaid have no ability to share in the savings generated.

5) What is working well with RCCO and BHO collaboration right now?

In one region the BHO and RCCO are collaborating closely to make care transitions seamless, but this is not the experience across the state. BHO and RCCO relationships appear to be limited, as CHCs are not aware of much collaboration at the patient level that could impact care.

6) What is not working well with RCCO and BHO collaboration right now?

Without a specific requirement to collaborate, integration seems to be a locally driven effort, and is not being mirrored in the relationship between RCCOs and BHOs as stated in question four. Having discussions at the regional level could lead to consistency across the region and assist in extending partnerships to all providers. Without regional level leadership, access to care depends upon local relationships; this creates gaps in access to services where relationships are not strong.

Sharing of data is a barrier at the practice level, and it is unknown what, if any, data is being shared between RCCOs and BHOs. Increased partnership regarding data sharing between systems could greatly benefit clients by improving patient centered care.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Integration of funding is central to a successful behavioral health integration, as stated in question 4. The RCCO rebid process should be used to begin developing alternative payment structures to accomplish this. Blended funding will lead to the best patient care by removing barriers to providing needed care, and it would be a good start to payment reform.

Both RCCO and BHO contracts should be required to demonstrate partnerships at the regional and practice levels, with transparent real-time actionable data to improve patient health. It would also be helpful for the RCCO and BHOs to work together to eliminate any perceived barriers to sharing patient level healthcare data to coordinate care.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	Carving out behavioral health funding creates silos which are an inherent barrier to integration.
Community Behavioral Health Services Rule	☒	☐	Rule places too much emphasis on providing high level care. To encourage preventative care and early intervention it should authorize receiving care through patient chosen providers, including PCMPs.
Covered diagnoses list	☒	☐	Too focused on severe and persistently mentally ill
Different behavioral / physical health reimbursement	☒	☐	This creates different systems of service with different outcome measures and objectives.
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	The CCAR is overly burdensome in primary care settings. The requirement to license substance abuse providers and facilities (vs. just providers as in other areas of behavioral health) creates a burden for primary care providers that could otherwise expand SA services on site.
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☒	PMPM itself is not a barrier, but the amount can be if it does not sufficiently cover expenses of required services.
Physical space constraints	☐	☒	
Privacy Laws (HIPAA, 42 CFR)	☒	☐	42 CFR in particular is a barrier, including over application/mis-application of current rules.
Professional / cultural divisions	☒	☐	CHCs providing onsite, integrated care have found that many behavioral health professionals need additional training to function in team based care models. Moving from the intensity of counseling sessions to brief interventions and opening and closing cases based on strict criteria to providing a broader range of

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

			behavioral health (vs. mental health) interventions is challenge for BH professionals new to the primary care setting.
RCCO or BHO contracts	☒	☐	See responses to questions 5-7
Staff capacity	☒	☐	CHCs face recruitment challenges for qualified staff.
State/Federal rules or reporting requirements	☒	☐	The narrow definition of behavioral health providers that are billable to a BHO create difficulty when partnership with CMHC is not possible.
Technical resources / data sharing	☒	☐	The systems are often not in place or extremely expensive to implement and maintain to share data between providers. Data sharing between RCCOs and BHOs if done, is not shared with PCMPs.
Training	☒	☐	Training on how to work as a member of an integrated team is not readily available, so integrated practices are recruiting from a narrow group of behavioral health providers who already have the needed experience.
Others			

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

It is also important to include oral health care to achieve whole-person/whole-family care. Across the state, CHCs demonstrate how to care for the whole person by focusing on all three elements: physical, behavioral and oral health. While not every clinic is providing all services on site, they are all committed (and federally required) to addressing the needs of their patients in a comprehensive way through service provision and community partnerships.

Not only are CHCs demonstrating the possibility of comprehensive care, but the benefits: Colorado Department of Health Care Policy and Financing data shows that CHC patients have one-third few emergency room visits, hospital admissions and primary care preventable hospital admissions than private FFS providers.

It would be helpful for the state to maintain consistency between the ACC expectation regarding integration and what is contained in the State Innovation Model (SIM) proposal presented to CMS. Of particular importance in the SIM proposal is the expectation that integrated care requires integrated, on-site teams of behavioral and physical health clinicians working on a unified care plan. Pharmaceutical management, integrated health records, and providing comprehensive primary, preventive and sick care are also necessary for a practice to be integrated.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Integration of funding in Medicaid for mental and physical health is required to make primary, preventative and behavioral health services more efficient and patient centered. The money should follow the patient – if a patient receives his/her mental health care at a CHC, the CHC should be able to bill HCPF directly for those services. Payment systems and contracts for behavioral and physical health must reimburse for preventative services. The current behavioral health payment system is designed to respond primarily to individuals with behavioral health diagnoses, as opposed to paying for early psychosocial and behavioral intervention for individuals and families with risk factors. Behavioral health prevention and health promotion efforts are critically important to cost effective, patient centered care.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

The Safety Net Medical Home Initiative (SNMHI) provides the most comprehensive definition of care management, and the National Committee for Quality Assurance (NCQA) provides the most comprehensive tool to measure the implementation of care management in a practice.

SNMHI defines the key charges of care coordination as: linking patients with community resources to facilitate referrals and respond to social service needs; integrate behavioral health and specialty care into care delivery through co-location or referral agreements; track and support patients when they obtain services outside the practice; follow-up with patients within a few days of emergency room visit or hospital discharge; and communicate test results and care plans to patients/families.

NCQA's assessment of a provider's care coordination and care transition system focus on three elements: test tracking and follow-up; referral tracking and follow up; and coordinating care transitions. The specific elements outlined in these three areas provide a comprehensive image of whether the organization providing care coordination has the procedures and mechanisms in place to provide the care as defined by SNMHI.

b. How should RCCOs prioritize who receives care coordination first?
c. How should RCCOs identify clients and families who need care coordination?
d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

We do not recommend a prescriptive approach to care coordination as it has been the experience of our members that State requirements are often pushed down to the PCMP, often without regard for the PCMP's system of care. PCMPs and RCCOs should work together to develop systems for identifying those most in need of care coordination supports, and the value of having a local care coordination provider should always be considered in identifying if the service is best offered by the RCCO or the PCMP.

12) What services should be coordinated and are there services that should not be a part of care coordination?

We don't believe that any services should be explicitly excluded from care coordination. There are however several areas that require further development:

- Specialist Communication: Communication between specialist and primary care providers needs improvement. Closing the communication gap between the PCMP and specialist is necessary to ensure that care coordinators have full information on patient needs and an up to date care plan.
- Pharmaceutical care coordination has primarily been focused on punitive measures that identify abuse in the system. Incorporating medication management more fully into care coordination will address those concerns, while also reaching patients in need of further support with their medication.

- Reducing emergency room utilization for non-emergent care continues to be an area of focus to reduce costs. All regions do not have systems that allow care coordinators to know when a patient has presented in the emergency room so follow up can be completed. Additionally, hospital systems tend to focus on what is needed to discharge a patient, not on connecting patients with providers who will continue care after discharge. Focusing on the relationship between PCMP and RCCO care coordinators and hospital systems will help address both of these issues.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

Psychosocial information such as where the patient lives, with whom the patient lives, and what resources he or she has are key to understanding what kind of care coordination is needed. While access to the patient's medical and behavioral health records are essential, these often do not include the information that needs to be a part of the patient record for successful care management.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

    a. What care coordination is going on today?

From the experience of CHCs, two predominate models of care coordination have been identified. The first is care coordination which is disease-specific. Patients with disease-specific care coordination may have more than one care coordinator within the same health system. The second predominant model incorporates care coordinators into the care team, across diseases and various community partners. Regardless of which model is being used, it is likely that patients are engaging with other health care providers and care coordinators. To reduce duplication and improve outcomes, PCMPs need access to more complete and timely patient care data to provide meaningful care coordination across oftentimes disparate systems.

    b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

Different organizations have coordinators dealing with different issues (i.e. housing, food access, etc.) and the work being done by those organizations may have a profound impact on the overall health of a patient. Unfortunately, if a relationship doesn't exist between the PCMP and the outside organization(s), there is no way to identify those potential impact areas, or for the primary care provider to coordinate care for the whole person/family. To address this issue, there may be a role for RCCOs in convening coordinators across community and social service agencies to increase communication, share data, and reduce duplication of services.

    c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

It is important to recognize that care coordination happens at the local community level, and not at the ACC program level. Care coordination is often done by individuals with a variety of titles and training, such as Transition Coordinator, Care Navigators/Coordinators, and Case or Care Managers. In exploring what is already in place in a community, it is important to focus on the functions and outcomes, not titles.

d. What are the gaps in care coordination across the continuum of care?

PCMPs need access to real-time patient clinical information in order to providing meaningful care coordination. This is lacking in the current model in many regions. Access to real-time, actionable data needs to be prioritized in the RFP.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

The areas identified in the table below are functions that the organization providing care coordination should be providing. Across the state, CHCs have care delegation agreements with RCCOs and in those situations the responsibility for coordinating with community supports and services on these issues would typically be delegated along with other responsibilities to the PCMP. In instances in which the RCCO is providing the care management (no care delegation in place, non-attributed patient, or patients attributed to PCMPs without a delegation agreement), the RCCO does have the responsibility for coordinating on each of these issues as needed within the region.

Non-medical need:	**Should the RCCO have a role?** Yes	No	**Should the RCCOs coordinate with community supports and services?** Yes	**Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?**
Abuse, neglect, and trauma	☐	☐	☐	See narrative above for this table
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	

Health literacy	☐	☐	☐	
Housing	☐	☐	☐	
Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	
Transportation	☐	☐	☐	
Other				

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Care coordination models should not be dictated by the state or RCCO. Focus should be placed on the outcomes desired (see response to question 19), not on restricting or defining the providers or provider team. RCCOs and PCMPs with care coordination delegation should have the flexibility to create a system that works for their population in achieving those outcomes.

Type:	**Coordinate care?** Yes	No	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☐	☐	See narrative above for this table
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	

Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other			

17) **Care coordination requirements for specific populations**. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

RCCOs should be required to establish mechanisms for community level care decisions.

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	See narrative above for this table
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	

Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

RCCOs should connect with and complement existing resources to support children today. There should not be duplication or replacement of existing structures. RCCOs should be connecting with regional resources and supporting PCMPs with delegated care coordination in accessing existing resources and structures for this population.

19) How should care coordination be evaluated? How should its outcomes be measured?

KPIs should continue to be used to evaluate outcomes. Additional measures that could be used are reductions in the cost of total cost of care, reduction in number of emergency room visits for non-urgent issues, and patient experience and satisfaction.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

The cost of providing care coordination services varies depending on a number of factors, including volume of clients. In particular, rural areas can be more expensive because of lower volume. Budgetary constraints should not be the only consideration in setting PMPM rates, rather these amounts need to be justifiable

through a valid actuarial process. As payment reform moves forward, transparency in what is included in delegation contracts and the justification for the PMPM amount will need to be established.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

Yes, but only if the variation in PMPM by population or age is actuarially sound.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

We do not believe that care coordination models should be dictated by the state or RCCO. Focus should be placed on the outcomes desired (see response to question 19), not on the allowed providers or provider team requirements. RCCOs and PCMPs with care coordination delegation should have the flexibility to create a system that works for their population in achieving those outcomes.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

The Department should continue to utilize KPIs to demonstrate the effectiveness of care coordination. Evaluation metrics that are based on national accreditation and that are consistent with other programs (such as Medicare, CHP+, etc) are ideal, so as to not create multiple workflows within clinics measuring metrics across various populations and payors. 5ee response to question 19 for specific outcome measure examples.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Care coordination models should not be dictated by the state or RCCO. Focus should be placed on the outcomes desired, not on the allowed providers or provider team requirements.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Colorado's CHCs have 169 sites spread throughout the state and several CHC span across multiple RCCO regions. Given this, some of our CHCs must manage relationships with up to 4 different RCCOs. Due to this fragmentation, there are many areas where consistencies across RCCOs would improve system efficiency.

Uniform RCCO governance structure is one area that should be addressed. We suggest that RCCOs be required to include:

- Consumer representation within the governance structure;
- Governance seats designated for large volume providers within the RCCO, such as CHCs; and
- Administrative expenses reported transparently and be limited to no more than a 10% administrative cost threshold (further information in Question 25).

The following functions should be standardized across RCCOs:

- PCMP reporting to RCCOs and standards for reporting needs to be standardized. It is administratively burdensome to large provider systems that serve patients in multiple RCCOs to meet varying requirements on what data and how it is provided.
- RCCO reporting to PCMPs needs to be standardized and presented in a way that allows practices providing services in multiple RCCOs to analyze their overall impact on the Medicaid population served.
    - This data should be real time to ensure care coordination and quality improvement efforts are meaningful
    - RCCOs should provide comparison data to all providers based on provider type (e.g. CHC, non-CHC, practice size, etc.)
- Referral protocols - currently the referral protocols submitted by the RCCOs vary in intensity, creating an unmanageable system of expectations for PCMPs and specialists serving patients in multiple RCCOs.
- Communication from RCCOs to PCMPs should be streamlined and RCCOs encouraged to partner in communicating to providers that serve multiple regions. In particular, attending meetings for multiple RCCOs which cover the same or similar information is administratively burdensome and unnecessary. Cross RCCO communication would allow RCCOs to identify areas in which they do not align to communicate differences to PCMPs more effectively and allow conversation regarding areas to create alignment.

Finally, as the state moves forward with payment reform, consistency will be needed in how providers are paid and large systems need to have the flexibility to choose a single RCCO with which to contract. Our response to question 26 contains further discussion of the complications of a single system managing multiple payment methodologies for a single population.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Transparency is central to being successful in establishing community relationships. Transparency should include RCCOs reporting all real and perceived conflicts of interest, reporting regularly on how state funds are being spent within the region, and including provider and consumer representation in the decision making process. Reporting on how funds are allocated and spent by the RCCO, and capping administrative spending by the RCCO to 10 percent, would provide additional accountability and ensuring that 90 percent of funds are spent improving patient care and access to care.

In addition to expectations regarding transparency, we recommend setting the expectation for community relationships in the RFP process by requiring applicants to include letters of support from community organizations and safety-net providers and hospitals, including CHCs. To evaluate the strength of those relationships, applicants should include information on the length and extent of their relationship with those partners. Additionally, a clear plan for or explanation of their community engagement process should be included, contain what community meetings are attended and the RCCOs advisory committee structure. These processes should include a mechanism for improving community level care decisions.

Finally, require clear contract oversight and enforcement to ensure that RCCOs successfully engage the communities in their region.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

Large PCMPs with sites in multiple regions should be able to select a single RCCO. The Department has stated that simplicity is one of the pillars of the ACC, and the ability to select a single RCCO decreases complexity both for CHCs and the state. As discussed in earlier questions, working with multiple RCCOs creates administrative complexities and presents barriers to future innovations to improve patient centered care, particularly around payment reform.

RCCOs themselves are very diverse organizations with different approaches to payment reform, referral processes, care coordination, and willingness to partner on innovative approaches to care. When working with multiple RCCOs, PCMPs are faced with challenges as simple as the time commitment required to attend multiple meetings on similar topics, to the difficulties of aligning systems with multiple systems, including billing systems should the RCCOs become a payer. Being able to work with a single RCCO would eliminate the complexities and allow large provider systems to work more closely with that RCCO to identify areas for improvement and innovation.

In addition to the efficiencies created, the ability to work with a single RCCO is a requirement for CHCs to pilot payment reform. A Medicaid payment pilot would have to involve all or most Medicaid patients in a single CHC system to be successful.

We recognize that this is a departure from the way the program is currently structured and there are several considerations that will need to be discussed. One of the original principles of the regional distribution was the equitable distribution of lives, so the issue to consider now is if equitable distribution is still necessary with the increased number of patients covered in the program.

A second area to consider is attribution. There would need to be a mechanism in place to ensure that RCCOs attribute patients to providers within their region fairly and equitably among PCMPs with capacity for more

patients. Additionally, attribution to RCCOs is currently done based on the patient, so the criteria for how large provider systems would be attributed to a RCCO have not been established. We are interested in continuing this conversation with the Department to ensure that the implications for either the decision to maintain status quo or allow this change are understood by all impacted. We believe there are options to address each of the concerns that would lead to an equitable solution that will be beneficial to RCCOs, PCMPs and patients.

If this change is determined to not be feasible, we would ask that the Department work directly with CHCs to pilot CHC payment reform, and work with the CHCs/CHPA and the RCCOs to determine how and whether RCCOs would be involved.

27) Should the RCCO region maps change? Why or why not? If so, how?

Regions should reflect the natural referral patterns and clinical appropriateness rather than administrative simplicity concerns. As an example, Larimer and Weld counties have a lot of overlap between providers, hospital systems, and referral patterns between Loveland, Greeley and Fort Collins, yet are divided between RCCOs. These divisions may not have an impact on referral patterns or access to care currently, but as RCCOs develop medical neighborhoods they could increasingly become an issue.

In addition to the example above regarding community referral patterns, the division of natural communities, such as metro areas, creates difficulties in establishing community relationships and partnerships. For example, the Denver metro area is divided between three RCCO regions. Two of those regions share an administrative organization, but with the patient population served by Medicaid it is a recurring issue that patients move, and in doing so change RCCOs which creates communication issues.

We believe that the RCCO region map should be evaluated based on the concerns of providers in those regions. Therefore, we are not making specific recommendations regarding changes, but have asked CHCs to submit comments regarding the challenges and strengths of the region(s) they serve.

28) Should the BHO region maps change? Why or why not? If so, how?

Payment systems must be integrated in order for behavioral and physical health to be fully integrated, so alignment of regions is a logical first step to integration of care.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

The required time for successful transition will largely depend on the structure of the new vendor. If the vendor selected is currently serving as a RCCO in a different region, the transition should take less than three months as attention can focus on changes to contracts with providers and care coordination delegation. If the organization is a new RCCO contractor, systems not already in place would be implemented upon contract

award, but it may take up to six months to establish IT systems with partners including hospital, PCMPs, specialists and care coordination organizations.

In either scenario, CHPA feels that the following requirements should be established:

- There is no disruption in payment to providers,
- There is no reattribution of patients to PCMPs, and
- A successful transition should be measured by provider feedback.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

In order for patient designated attribution to work better, Health*Colorodo*'s contract should include the following:

- If a patient does not select a PCMP after a designated time period, auto attribution to a narrow group of high volume, high quality providers is implemented. Screening criteria for eligible providers should include items such as: practice open to new Medicaid patients, practices with delegated care coordination agreements with the RCCO, practices with national Patient Centered Medical Home recognition or other similar standards, practices with electronic medical records capable of running reports for patient population health management and quality improvement, and practices contracted with CORHIO.
- Appropriate call center staffing levels to minimize wait times to under S minutes and a system implemented which allows patients to leave a number and be called back by a representative rather than remaining on hold.
- Funding and accountability to assure efficient and accurate patient designated attribution.
- The ability for clients to designate their PCMP on the Medicaid application, both on paper and through PEAK.
- Ability for all Medicaid clients, new and those previously enrolled, to submit PCMP selection and changes through a fax or online form which receives a confirmation receipt for both the patient and selected PCMP.

In addition to the changes to the Health*Colorodo* contract regarding attribution, HCPF should implement policy in which providers that can demonstrate having served as the PCMP between enrollment and attribution receive retroactive PMPM payment.

The following waivers or SPAs should be sought from CMS:

- Waiver to allow patient assignment or lock in to providers. This will be necessary to move forward with payment reform because providers cannot be held responsible for managing patient health outcomes if the patient does not have an obligation to utilize the assigned provider.
- SPA to utilize projected annual income for Medicaid determination.
- Waiver to allow 12 months continuous eligibility for adults in order to address issues of churn.
- SPA for alternative payment mechanism for CHC payment once the methodology is developed and agreed to.

Suggested changes to the RCCO contracts have been outlined in Questions 24 and 25.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

The two primary limitations that need changes are regarding the cap on dental services for adults and case management restrictions.

- The need for dental care exceeds the $1,000 cap and is limiting the ability of providers to provide high quality care in an efficient time frame in order to reduce further cost implications in the future. If patients cannot afford to continue treatment after the cap the state risks those needs elevating from a simple dental procedure to an emergency room case.
- Case management is not included in the benefit structure, though it is provided by CHCs and reduces the overall cost of care. Adding case management to covered benefits would allow expansion of the service, ultimately decreasing the overall cost of caring for the population.

Additionally, the current benefit structure does not incentivize patients to utilize less expensive, more appropriate care settings. A lot can be accomplished through providers and care coordinators, but structuring the benefit to further incentivize patient choice would further these efforts.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

No, CHCs have already experienced the complications of working with multiple RCCOs and expanding the number per region would only accentuate the problem. Additionally, multiple RCCOs per region adds a degree of complexity to not only the provider level, but processes such as attribution.

While multiple RCCOs in an individual region should not be an option, there should be the ability for providers, such as CHCs, within a RCCO to partner and be acknowledged as a separate provider group or type within the RCCO. This would be beneficial in providing a mechanism for practices to track impacts and savings on a more localized level.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

All CHCs are Medicaid providers.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

RCCOs should be responsible for ensuring that everyone selects a PCMP within the first three months of enrollment. As enforcement of this responsibility, RCCOs should lose PMPM entirely for those who remain unattributed after three months. Patients should be attributed to all high-quality PCMPs meeting specific requirements (stated above) with capacity to take on additional patients.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

The Department of Public Health and Environment (CDPHE) already tracks many population level health trends which would be of use to the ACC Program. Likewise, information gathered regarding the Medicaid population through the ACC would be beneficial to CDPHE in expanding their data set. Additionally, CDPHE tracks data regarding emerging public health issues which would be beneficial to share in a timely fashion with providers, and providers could be a useful resource to CDPHE in responding to emergency situations. Collaboration around bi-directional data sharing should be built for the benefit of both programs.

Perhaps even more impactful is the relationships at the local level. RCCOs should have a requirement to collaborate with Local Public Health Departments.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

The ACC and DHS should, at a minimum, compare goals to ensure alignment. This would be accomplished best at the Governor's Cabinet level.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

The two programs should align eligibility determination methodology. For example, the two should align income requirements to annual income projections, and Medicaid adults should receive 12 months continuous eligibility. Aligning these two elements will reduce churn between the programs and increase consistency of care for patients.

Until the necessary alignments can be accomplished, Connect for Health Colorado and the ACC Program should work closely to ensure that patients whose eligibility changes and movement between the programs is necessary have consistent access to primary care.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

The ACC Program should collaborate with DOI to utilization of the Medicaid definition of Essential Community Providers is consistent with the definition in the private insurance market to ensure consistent access to ECP providers in both public and private insurance settings. Additionally, the DOI should be an active participant in payment reform discussions and evaluation of models which include risk.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

As referenced in response to question 24, RCCOs should have a uniform governance structure which requires at least two consumer representatives. These representatives should be clients, client family members or client advocates.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

Please see question 24. RCCOs should have a uniform governance structure which requires representation from providers, community organizations and others in the region.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

See response to question 40.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

The Department should continue to host one to two regional stakeholders meetings per year like those hosted spring, 2014 which were well attended. It is important that HCPF leadership and ACC staffs have a presence in each region at least once per year.

ACC PIAC and subcommittee meeting materials should be posted at least two business days in advance of meetings. Agendas for these meetings should have items for public input clearly articulated so stakeholders can come prepared to meetings to share their input.

Finally, to encourage and ensure stakeholder engagement, the Department must have technology that allows stakeholders outside of the Denver metro area to actively participate in meetings. Current call-in systems do not support active participation.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?
    a. If no, what are the gaps?
    b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

The increased enrollment in Medicaid has exacerbated the issue of obtaining timely access to behavioral health treatment and therapy, dental care and specialist care. CHC dental programs are overwhelmed with the pent up need among both those previously enrolled in Medicaid and the expansion population. Additionally, the expansion of Medicaid has made waiting lists for specialty care longer, which is particularly true in rural areas.

A large part of the problem with accessing care is the lack of providers accepting Medicaid, and part of that is driving by the lack of incentives for hospitals and specialists to engage patients and respond to the population needs. RCCOs should have the flexibility and the charge to work with providers in their regions to develop these incentives.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

    a. What role should hospitals play in the next iteration of the ACC Program?

One of the central roles that hospitals need to play is engaging with the RCCO to remove roadblocks to sharing information with PCMPs. Having access to real-time data about patient access of services in a hospital setting is essential to care coordination and engaging patients to utilizing PCMP services before an issue requires emergency care. RCCOs should develop plans to incentivize hospitals to engage in this work, to engage patients beyond just providing emergency care, and mechanisms to dis-incentivize not participating.

    b. What role should pharmacies play in the next iteration of the ACC Program?

Pharmacists should have increased representation at RCCO/regional meetings. As mentioned in response to question 12, pharmacy is an area that needs to be increased in care coordination work. Pharmacists can be contributing to care coordination through medicine reconciliation for patients and working with care coordinators to educate patients.

    c. What role should specialists play in the next iteration of the ACC Program?

RCCOs should be required to create a care transition system that includes specialists, hospitals, pharmacies, home health, hospice and PCMPs.

d. What role should home health play in the next iteration of the ACC Program?

RCCOs should be required to create a care transition system that includes specialists, hospitals, pharmacies, home health, hospice and PCMPs.

e. What role should hospice care play in the next iteration of the ACC Program?

RCCOs should be required to create a care transition system that includes specialists, hospitals, pharmacies, home health, hospice and PCMPs.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

RCCOs should have community advisory boards which include representation from SEPs, CCBs, counties, local public health agencies, and other community health organizations and nonprofits.

g. What role should counties play in the next iteration of the ACC Program?

RCCOs should have community advisory boards which include representation from SEPs, CCBs, counties, local public health agencies, and other community organizations and nonprofits.

h. What role should local public health agencies play in the next iteration of the ACC Program?

RCCOs should have community advisory boards which include representation from SEPs, CCBs, counties, local public health agencies, and other community organizations and nonprofits.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

Provider associations, including CHPA, and organizations that provide care coordination and management services should be included at the ACC and RCCO levels.

45) How can RCCOs help to support clients and families in making and keeping appointments?

RCCOs should utilize client no show rates to identify those patients potentially in need of care management and use their care management teams to find and address their root problems. RCCOs should work with their delegated practices on how to partner around no shows. Additionally, RCCOs could support PCMPs in

implementing practice level interventions, such as implementing recall or appointment reminder systems, through technical and financial support.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

The functions described should be included in each region's care coordination approach, but the specifics of job titles and the mix of providers should not be prescriptive. Community Health Workers are most effective at the PCMP level within the community, so it should be an option for PCMPs and organizations with care coordination delegation but it should not be a requirement. The focus should be on developing locally appropriate systems that fulfil the functions and meet identified outcomes.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

All options could be viable options for reimbursing for the work done by Community Health Workers, but see question 46 for thoughts on the appropriate level for utilizing these workers.

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☒
On staff (salary) at RCCO	☒
Per Member Per Month Payment	☒

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

The dental ASO's contract contains the responsibility for ensuring an adequate network of providers, so this should not be a focus of the RCCO. However, as the RCCOs are more locally focused and have established relationships in the community, they would be a good partner for the ASO to utilize in establishing those local relationships and identifying providers.

RCCO care coordinators should include oral health and accessing dental services in their efforts to get patients appropriate and timely care. To accomplish this, the RCCO should have established relationships with the

appropriate ASO staff. Additionally, RCCOs should be providing encouragement and education to patients about the importance of regular, preventative oral health care.

The CHC model of care integrates physical, behavioral, and oral health care in a patient centered setting. Throughout this RFI there is significant focus on the first two components, but little on oral health. As RCCOs provide support and trainings to practices regarding integrated care, they should be highlighting the importance of oral health in whole-person care, total cost of care and quality improvement. Additionally, RCCOs should be educating providers on options for including oral health in medical practices, including independent practice dental hygienists as an option in Colorado.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

The National Committee for Quality Assurance define cultural competency as not only having empathy, but expressing it towards patients regardless of the patient or provider's cultural background. In order to do so, clinical and non-clinical staff must have an adequate understanding of their patient population including its diversity, health literacy, language needs, etc. With understanding of the patient population, providers are encouraged to utilize motivational interviewing as a technique to facilitate culturally competent conversations.

b. What RCCO requirements would ensure cultural competency?

All clinical staff should be trained in motivational interviewing and enroll in cultural competency trainings with continual follow up, both of which RCCOs can provide or facilitate connections to. RCCOs should also require practices to determine cultural competency standards and hold them accountable for meeting training all staff about and meeting those standards.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all clients/families including those with low health literacy?

See response to b.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Bilingual or translation services, on-site staff with expertise in cultural competency, and ensuring that every patient completes a health literacy assessment are factors that contribute to enhanced cultural competency.

Skills learned during trainings would incorporate the ability to refrain from making assumptions and would ideally educate participants on what it means to have implicit and explicit biases.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

Yes, these should be allowed to enable payment reform. Preferred networks help manage population health and generally help reduce waste in the continuum of care, but without movement towards payment reform, RCCOs will not have the ability to develop or enforce these networks.

If payment reform options with any element of risk, even if only partial, are to be considered in the next RFP, networks of preferred specialist, facility and ancillary providers must be allowed. The development of these networks will need to be coupled with enhanced prior authorization processes to allow RCCOs and PCMPs to reduce total costs, improve outcomes and improve patient care.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

At the patient level the ACC should evaluate options for slight changes to patient co-pays which would disincentive inappropriate use of emergency rooms, particularly where other care options are available. Additionally, not all hospitals are actively participating in ACC. A combined effort by RCCOs and the state should build additional mechanisms into the ACC which will engage more hospitals.

At the regional level, RCCOs should be developing community diversion strategies where one is not in place. Partnerships between PCMPs and hospitals have been highly successful in redirecting patients to primary care when more appropriate and making that care available, and RCCOs could be bringing community partners to the table to begin these discussions. Additionally, RCCOs have access to data which would allow them to analyze emergency room practices to identify outliers. Understanding if there are emergency rooms that cost significantly more than others in the region or extensive use of tests without clinical reasons would identify opportunities to reduce unnecessary care.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

The specialist network for Medicaid patients is highly limited. RCCOs need to have the authority and charge to develop incentives to encourage specialist and hospital participation.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

A high functioning RCCO should be able to provide all of these supports as needed to practices, though it should be recognized that not all practices will need these supports and therefore none should be tied to a specific tool. As PCMPs who have care management delegated, our members have most of these elements in place, and requiring a specific tool would require additional administrative work to utilize both the PCMPs process and the RCCOs, and would likely require financial investments to incorporate a duplicative function.

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☒	☐	☐	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☒	☐	☐	☐
Provide registries	☒	☐	☐	☐
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☒	☐	☐	☐
Supply behavioral health surveys	☒	☐	☐	☐
Supply other self-screening tools	☒	☐	☐	☐
Administer behavioral health surveys	☒	☐	☐	☐
Administer other self-screening tools	☒	☐	☐	☐
Prepare client action plans	☒	☐	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☒	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☒	☐	☐	☐
Provide standing pharmacy order templates	☒	☐	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☐

Provide directory of other resources	☒	☐	☐	☐
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

No specific tool should be required. Smaller practices and those without care delegation may need higher levels of support or templates to use, but practices that have care management delegation and existing processes in place should not have to change or duplicate work and financial investments to meet a RCCO specific requirement. In particular for situations in which providers serve patients from multiple RCCOs, requirements of specific tools would create additional barriers to providing patient focused and cost effective care.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

RCCOs should provide resources and support as requested by practices, but they should not be prescriptive. Especially practices that are already engaged in medical home efforts, such as CHCs engaged in Patient Centered Medical Home certification, should be able to evaluate their practice's needs and drive the support needed from the RCCO in addressing those areas. In order to accommodate both practices such as CHCs that are actively engaged in advancing the medical home model and those practices which are newer, RCCOs could consider a grant program that would allow practices to propose changes and needed supports from the RCCO.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

Established national standards, such as the National Committee for Quality Assurance's Patient-Centered Medical Home Recognition, are the most effective way to recognize a PCMP's capacity to service as a medical home for patients. These standards set expectations of what is expected of a medical home that are consistent regardless of the region and have an established process for recognition.

Practices should be compensated for their level of recognition through these national standards, with practices incentivized to improve their rate because it is tied to increased PMPM or capitation payments.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

All PCMPs should utilize a registry or electronic medical record that has the capability of running reports for population health management and quality improvement as that is the standard of care. This should be a requirement for practices to be eligible for auto-attribution as discussed in response to question 30.

58) Please share any other advice or suggestions about provider support in the ACC.

High performing PCMPs need to be rewarded based on their performance. Currently in the ACC recognition is primarily at a regional level, which does not encourage further development of those high performing practices. RCCOs should be required to report and reward individual practices.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

No, the current payment structure is still paying for volume, not quality. As discussed in response to question 58, providers are not being rewarded or tracked by their own individual performance which is not providing incentives to low performers to improve or for high performers to continue to develop. Additionally, as discussed in response to questions 4, 43, and 52 there is no incentive for specialists to participate and engage with patients in a meaningful way.

The Shared Savings component of the ACC is particular limited in its ability to recognize and reward high performers – many measures can only be attributed to the region, which may result in a high performer being left out of payments due to poor performance by providers elsewhere in the region. The size and geographic diversity of many of the regions prevent meaningful coordination and care improvements between providers, and it must be recognized that in most cases, these providers never agreed to work together or to be at risk for another provider's performance.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

CHCs are interested in working with HCPF to develop and pilot an Alternative Payment Methodology (APM) that moves away from FFS and towards population-based payment. Many CHCs are interested in taking on additional risk over time. Other states are piloting converting the PPS rate into a PMPM for primary care.

In a capitated payment structure, the initial PCMP cap should include physician services, non-E&M PCP services, and OP Labs/Pathology as these are services primarily handled by PCMPs. In later years the program could begin to expand into additional services, such as diagnostic imaging, PT/OT/ST, DME (with agreed upon carve outs), and OP Radiology (professional services only). Ideally all three elements of integrated, whole person care (physical, behavioral, and oral health) would be included.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

CHCs as providers do have the infrastructure to support value based payments, however additional resources would be needed to add expertise at the State and RCCO level for rate setting. Without rate setting expertise and third party validation, CHCs cannot risk PPS/APM and expect to remain viable.

One of the other large barriers to managing a population successfully and being paid based on value is the lack of real time, meaningful data as has been mentioned in response to questions 2, 6, 8, 14, 24, and 44. Helping to facilitate real-time data sharing between PCMPs, facilities, specialists, and community providers must be a requirement of RCCOs in order for value based payments to be accomplished.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

For providers, the need to obtain licensure will be prohibitive to participation in a model involving risk. There are models utilized, both partial risk and capitation, which do not require a DOI license if sufficient reserves are held. The Department should evaluate options for payment reform models which will not require DOI licensure.

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

For CHCs, it may make sense for the state to remain the payer to resolve the potential of large CHC systems being subject to different payment pilots or methodologies in each region where they have patients. This could also be resolved by allowing CHCs to choose a single RCCO. Regardless of the direction taken, all parties involved (CHCs, RCCOs and the state) will need to work together closely to determine the appropriate role of the RCCO in payment distribution. See also the response to question 25, 50, 68 and 75.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

As discussed in response to questions 58 and 59, high performing PCMPs are not currently incentivized to continue to improve their practice, a concern that payment reform needs to take into account. Providers who are responsible for care improvement and cost savings should be rewarded with shared savings and incentive payments.

The vision of RCCOs is to increase system effectiveness, but the care and decisions made regarding payment and practice reform most greatly impact the PCMP. To address this negotiations regarding payment reform need to be with the PCMP providers with RCCOs as a partner.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

Measurements such as clinical data on behavioral health, oral health, chronic and acute care services, unhealthy behavior, and factors that contribute to care such as social determinants of health and assessment of health literacy should be used to measure impact.

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	In 2012, CHPA worked with our members to establish patient satisfaction measures that would meet the NCQA PCMH requirements. The full CAHPS survey is composed of S2 questions and the administration of it in entirety was felt to be too administratively difficult to implement. CHCs did agree to utilize and report on S questions from CAHPS, and we would advocate considering this shortened version to evaluate patient satisfaction: 1. In the last 12 months, how many days did you usually have to wait for an appointment when you needed care right away? (a. Same day, b. 1 day, c. 2 to 3 days, d. 4 to 7 days, e. More than 7 days) 2. In the last 12 months, how often did this provider explain things in a way that was easy to understand? (a. Never, b. Sometimes, c. Usually, d. Always) 3. In the last 12 months, did anyone in this provider's office talk with you about specific goals for your health? (a. Yes, b. No) 4. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 12 months, did you see a specialist for a particular health problem? (a. Yes, b. No – if no, skip question 5) S. In the last 12 months, how often did your provider seem informed and up-to-date about the care you got from specialists? (a. Never, b. Sometimes, c. Usually, d. Always)
SF-12 Health Survey	☒	☐	This tool is not used by CHCs at this time, so while we have no objection to it being an option, it should not be the only tool available.
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☐	☒	The tool is not used for patient satisfaction, primarily a patient education tool
Focus groups	☒	☐	
Other	The state should focus on patient satisfaction tools, not patient education tools. Additionally, as referenced in other questions, tools should not be prescriptive and requiring practices to implement duplicative efforts.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

The Department should look beyond claims data to other partnerships that could be provided to develop data on population health, in particular through partnership with the Colorado Department of Public Health and Environment (CDPHE). Claims data, lab and pharmacy data, CDPHE's health survey data, and outside data sources such as the Colorado Health Access Survey could be utilized to measure population health until more robust and timely data tracking and measurement tools are in place.

In developing ways to measure population health the Department should not develop prescriptive tools for implementation in PCMPs, but should look for ways to mine data from what is already tracked by PCMPs.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

PCMPs should be included in the development of reporting models in order to ensure transparency in how their data is utilized and that reports are presented in a way that can be utilized to facilitate further improvements in their system. To address these concerns, a review system should be established to create and maintain transparency and integrity of data, and large PCMP systems, such as CHCs, should have representation in that system.

Quality and performance data should be reported to PCMPs consistently across RCCOs so that those who serve patients across multiple regions can better understand their impact on their patient population. Additionally, this data should be provided on a regular basis and should include comparison information demonstrating not only how the PCMP is performing in relation to itself, but also in relation to comparable practices and the region as a whole. Presenting comparison data is the only way to identify top performers and ways to learn from their system to achieve the triple aim.

69) **Measures for payment**. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

The problem has been the frequency with which the Department has changed measures. Impact cannot be measured over time if the measures do not remain consistent. Over time it would be feasible to add additional measures, but at the moment the Department needs to identify a set of core measures that will be maintained.

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☒
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

The percentage should start low and be increased over the period of the contract as policies and reporting systems need to be established in order to tie payment to performance. As referenced in response to questions 61 through 63, CHCs are interested in the development of models with capitation and risk corridors, but in developing those models we are opposed to a fixed formula regarding the percentage of payment tied to performance. The question should be regarding how to accelerate payment to high performing RCCOs.

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Yes, all regions should have the same KPIs, and RCCOs and providers should be working toward the same statewide goals. This is necessary because to achieve KPI performance large PCMP systems, such as CHCs, adopt organization wide quality initiatives which will impact sites across multiple RCCO regions.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Reimbursement should be based on progress toward meeting national standards, with ongoing rewards for those who meet or beat the standards. While it might be necessary to create incentives that are based on individual improvement to encourage movement towards national standards, payment systems should more heavily reward those that have meet and continue to beat national standards.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

Yes

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

Increased transparency, as discussed in response to questions 2, 24, 25 and 63, is necessary to strengthen relationships with RCCOs as it is not clear that funding is being sufficiently invested in care and the care system. To address this, RCCO's should have a ten percent administrative cost threshold. Additionally, a medical loss ratio standard should be established and RCCOs should have reporting requirements regarding funds spent and unspent.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

CHCs monitor and report performance publicly via the Uniform Data System and small amounts of funding are increasingly tied to quality payments, including:

- Performance in Medicare Advantage
- Meaningful Use has paid practices based on meeting quality outcomes with HIT PCMH attainment

CHCs are increasingly seeking and occasionally receiving reimbursement for performance on patient satisfaction, provider satisfaction, services and screening rates, and access and availability measures.

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other: As providers, CHCs find phone calls and face-to-face meetings to have the most success in communicating with patients. Some CHCs have begun to use text messages and all are working to get patients to use web portals. Meaningful Use requires the use of patient portals, but it is too early to know at this time if this will work with the population served.		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Responses in the table below reflect what the majority of CHCs in Colorado have. Individual CHCs have been encouraged to respond with their specifics.

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☒	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☒	☐
Practice assessment tools	☒	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☒	☐
Shared decision-making tools	☒	☐
Telemedicine software	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☐	☐	☒
Health risk assessment software	☐	☐	☐	☐	☒
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☒	☐	☐
Patient education wellness tools	☐	☐	☐	☐	☒
Provider/case manager directory	☐	☐	☒	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☒
Telemedicine	☐	☐	☒	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

The lack of access to timely, updated and accurate information regarding care sought outside of a CHCs system are needed to be actionable for care transitions and planned care. The lack of shared data systems is a huge barrier to this, but CORHIO is a quickly developing solution to this issue that should be utilized and encouraged.

The issue is the inability to share data across systems, not necessarily the systems themselves. Consequently, requirements from RCCOs to implement specific systems that don't align with a practice's existing system will not address the issue and will only create need for additional administration resources. RCCOs should work with their providers and CORHIO to address these issues.

81) How can Health Information Technology support Behavioral Health Integration?

The issue with technology and the integration of physical and behavioral health is not in relation to the capabilities of technology. As mentioned in response to question 80, CORHIO has been able to develop

mechanisms to bridge gaps between different systems in order to facilitate access to real time data. However, CORHIO has not been able to address the barriers related to sharing behavioral health information as the federal regulatory requirements on sharing this information are more burdensome. Changes are needed to the regulations that are preventing data sharing from behavioral health.

Without changes to regulation, integrating and sharing data between behavioral and physical health can only be done on an individual partnership level and will continue to require highly sophisticated systems. Until regulations can be changed, RCCOs sould be supporting local efforts to develop these systems.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

Yes, there needs to be a way to share data across systems in the next iteration of the ACC because without it there is no way to ensure that PCMPs across the state are getting consistent data, which is of particular concern for those participating in multiple RCCOs. As discussed throughout this response, this shared data and analytics platform should not create additional administrative burdens and costs for PCMPs, but should utilize available technology to share data across systems. In order for it to be useful, it must also meet basic requirements of transparency and timeliness:

- Transparency would be established by ensuring the ability to see background data being compiled and a vendor that is responsive to questions.
- Real time information about care accessed is necessary to provide timely, actionable data for care coordinators the information needed to address high utilizers now.

While individual care data is useful in care coordination, a shared data and analytics system should also be able to run useful reports on the population they serve as a whole. These reports should include outcome data and true cost of care comparisons rather than just percentage change information. Additionally, for PCMPs to control the cost of care they need information about the charges associated with care provided outside of their system. The data and analytics tool should allow providers to see if a hospital or specialist cost is significantly higher than another to enable the provider to make a smart referral.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

No. Refer to response to question 80 regarding the issue to address being the ability to share information across systems, not implementation of duplicative systems at the practice level.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

No. Refer to response to question 80 regarding the issue to address being the ability to share information across systems, not implementation of duplicative systems at the practice level.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

A provider directory should be searchable by provider, site, and/or entity; contain information on if they are currently accepting new ACC enrollees; and contain accessibility information such as hours of operation and languages spoken. Additionally, the provider interface should have a way to easily update information, contain provider contact information, and contain information regarding making referrals to the practice. On the patient side it should also contain quality information about the provider.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

As stated throughout this response, access to actionable, real-time data needs to be prioritized by the Department. PCMPs need access to more complete patient care and cost data, often across RCCOs, to effectively manage the population and provide care coordination.

In addition to the comments made in response to question 82, RCCOs should be working with providers, including PCMPs, hospitals and specialists, across their region regarding how data will be shared. These conversations should happen within a state wide context as often patients and providers cross RCCO region lines. RCCOs could both be supportive of efforts to join CORHIO to achieve the outcome of sharing actionable and timely clinical data, and be implementing requirements that providers engage in these efforts.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

There are many HIT solutions which would provide benefits to clients, providers and RCCOs. Patient access to web portals to track their health information and direct messaging with providers would be useful in engaging patient in their health. Telemedicine, especially in relation to accessing specialists, would beneficial in expanding access to care. Instant communication in the form of email or text when a patient presents in the ER would be beneficial to case managers.

In order for any of these to be utilized to the full extent of their possibilities, there needs to be a system in place for sharing data across systems. CORHIO is a locally developed solution that could be wider used to address this barrier.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

RCCOs should be encouraging or requiring participation in CORHIO and including technical assistance with that process, which would address a requirement that they should have to ensure the flow of information across systems. Additionally, RCCOs should be providing support to Meaningful Use implementation, which could be simply coordinating with organizations that provide support in this area

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

As mentioned throughout the answers to questions in this section, CORHIO has a large role to play in successfully developing the data systems which will allow real-time, clinical data to be shared, which is required to fully realize the benefits of care coordination. Many of the barriers that were alluded to in the questions of this RFI, such as is a single system needed for a particular purpose across a region, are issues CORHIO has already been working on solutions to, so they should be included as a partner in these efforts from the beginning.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 098

Accepted by: KJDW

Notes: Standard formatting applied

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Elizabeth Freudenthal
Location: Denver, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Association for School-Based Health Care
Location: Denver, Colorado
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☒ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☐ Yes
☒ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:

We support our members, the 56 school-based health centers (SBHCs) in Colorado. This response is compiled based on the direct input of many of our members, as well as our own ongoing work supporting SBHCs.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Colorado's SBHCs served nearly 32,000 unduplicated patients in the 2012-13 academic year. Of those, nearly 60% were covered by Medicaid. A full 25% of total SBHC funding comes from Medicaid payments. SBHCs typically help families enroll in Medicaid. Nearly all SBHCs are enrolled in their RCCOs. There are a few SBHCs who are trying to enroll in their RCCOs but are experiencing administrative difficulties.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

General Questions

1) **What is working best in the Accountable Care Collaborative (ACC) right now?**

For school-based health centers (SBHCs), the ACC program provides several benefits.

RCCOs help SBHC providers support better continuity of care for their patients. SBHCs serve patients as a primary care medical home, but they also see patients with other primary care providers. The RCCO helps all the providers that treat each patient communicate with each other about that patient.

SBHCs get reimbursements for the integrated care they provide their members. And they get data that they can use for improving their practices. For example, monthly reports about high emergency department utilizers help SBHC providers target those patients for comprehensive intervention, prevention, and care coordination activities.

From a systemic perspective, the ACC begins to lay a foundation for reimbursing SBHCs for the innovative care that they've been doing for decades in Colorado: integrated, place-based, whole-child health care.

2) **What is not working well in the ACC Program?**

There are three major issues facing SBHCs in the ACC program.

1. Many SBHCs have difficulty getting their patients attributed to them. They perform well child exams and increase that KPI for their RCCO, but they don't get the related incentive per-member-per-month payments because they are not the attributed primary care provider for those patients.

2. The current funding structure for behavioral health care is inadequate for meeting the needs of children and adolescents. SBHCs rely on the resources of their Community Mental Health Center (CMHC) to provide behavioral health care. Too often, the CMHC does not provide a staff member with regular, adequate hours at the SBHC. There is high staff turnover, and long waiting lists for students with urgent mental health needs. Many SBHCs provide behavioral health services without seeking reimbursement, or they rely on grant funding for behavioral health services. Many SBHC administrators and providers have sought CASBHC's support in getting direct reimbursement for the behavioral health care they provide.

    a. Another consequence of the SBHC's reliance on CMHCs for behavioral health care is that the SBHC and CMHC staff typically use different electronic health records. The incompatibility makes fully integrated care more difficult. CORHIO could help support efforts to better integrate existing EHRS and to distribute protocols for better coordination between behavioral health records and physical health records.

    If SBHCs could get direct reimbursement for the behavioral health care they are already providing, they could keep therapists on staff, fully integrated into their IT systems, confidentiality protocols, and culture. They would also be able to provide crucial services in

a more financially sustainable way. And with this financial sustainability, they would be able to support enough staff to fully meet the needs of their patients.

3. Some SBHCs have had difficulty getting acknowledged as patient-centered medical homes by the ACC. SBHCs meet all of the characteristics of patient-centered medical homes: They are whole-child-centered—more so than standard clinics, because they coordinate with each patient's school and address learning barriers. They provide coordinated, integrated health care, they are uniquely accessible to pediatric populations, and they provide culturally sensitive health care. They provide systematic referral services for times when clinics are closed. They routinely provide health education and other empowering programs, including youth health advisory councils and programs. They are the primary medical home for many of their patients.

Providers also described some ways that the data they get from their RCCOs could be more useful. There is currently a 3-4 month lag in processing time. That is a long time for pediatric providers to use the data to improve care for their patients. In addition, primary care data are provided as a lump sum. Providers cannot use this undifferentiated data to understand if their treatment plans are appropriate. Primary care providers have expressed the desire for expenses broken down to allow for better interventions.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

Many SBHCs form partnerships with the local community mental health center (CMCH) to provide mental health care and substance abuse treatment. The SBHCs with strong, positive relationships with their CMHCs are able to meet most of the health care needs of their patients. They are able to staff their SBHC with full-time providers who have the capacity to practice integrated care. With full staffing and close relationships, behavioral health providers are able to be present at well child exams and for "warm handoffs" between the medical and behavioral health provider. They are also able to have shared access to electronic health records, which simplifies tracking and coding and improves the quality of care.

4) What is not working well in the BHO system?

Expanding on the summary provided above, there are two specific structural barriers to SBHCs meeting the full need for behavioral health care at schools.

1. Individual BHOs control the ability for licensed therapists to get reimbursed by Medicaid for providing services to Medicaid patients.

   One Western Slope provider said, "[Our regional BHO and CMCH] don't have enough providers that are bilingual and culturally competent. They say that they don't need these providers. They say there are plenty of providers in our area, and it's not true. Our valley is half Hispanic, with 58% Hispanic children in our schools, and there is only one part-time, bilingual therapist in the valley. We have a lot of Medicaid kids that cannot wait for this provider to see them in 2-3 months. The BHO doesn't open their doors for other providers."

This site, and other sites in this situation, hire bilingual therapists to meet the needs of their patients. In-house therapists are more able to provide fully integrated care. They work closely with medical and other providers, and they can share the same EHR. They are located fully at school and have capacity to integrate their services with school programming as well as SBHC activities.

However, SBHCs are paying for these services with already-scarce grant funding, typically from the Colorado Department of Public Health and Environment (CDPHE). CDPHE's SBHC program is working hard to find a way to maintain funding for the expansion of the SBHC system over the next few years. CDPHE should not be funding provision of Medicaid-covered services to Medicaid-enrolled children and youth.

2. SBHCs rely on already-underfunded CMCHs for staffing. Even when the SBHC has a great relationship with their partner organizations, they do not have enough behavioral health providers to meet the needs of their communities. Even the SBHCs with the strongest behavioral health programs have expressed the clear need for more behavioral health staff. If therapists were paid higher wages, as well, there would be lower rates of workforce attrition and turnover. This would improve the delivery of integrated health care at SBHCs.

   If Colorado preserves the Medicaid carve-out, CASBHC recommends two changes that would meet the needs of SBHCs: Allow a neutral state agency, rather than regional BHOs, to provide Medicaid accreditation to behavioral health providers. And significantly increase the size of the carve-out to more fully fund behavioral health providers statewide.

   As one provider, whose relationship to her BHO is strong, said, "We need more. That's really the biggest thing. We need more clinicians and hours. Ours are stretched to the max. We use them completely to the fullest extent possible, and we need more."

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

SBHCs are well-positioned to provide the innovative, fully integrated, whole-child health care that the ACC prioritizes and that the health care field is increasingly recognizing is ideal.

Integrated into their school communities, SBHCs provide children and adolescents with culturally sensitive, person-centered care. They coordinate with teachers and administration to provide a supportive environment for Colorado's most vulnerable children and youth. SBHCs are required to have licensed therapists on staff, either through partnerships with their CMHCs or through their medical sponsors. These providers work closely with primary care providers and other providers treating each child or adolescent at the clinic. A majority of their patients are covered by Medicaid. Their Medicaid patients' behavioral health care needs remain largely unmet, due to structural barriers described above. SBHC providers should be reimbursed by Medicaid for the behavioral health care services they offer to their Medicaid patients.

SBHCs have been pioneering team-based, integrated health care for decades in Colorado. If the ACC is going to provide fully integrated health care, they can look to Colorado's school-based health centers as a model for all medical homes.

However, the current funding streams for behavioral health care constitute significant barriers to SBHCs providing fully integrated, comprehensive health care that's financially sustainable.

If Medicaid would reimburse SBHCs directly for the behavioral health care that they already provide, SBHCs can provide the best possible integrated health care for Colorado's most vulnerable children and youth.

For a practical next step, HCPF could collaborate with CDPHE and CASBHC to pilot a program testing reimbursement for behavioral health services at a few school-based health centers. This pilot could include fully integrated behavioral health care as an incentive in the per member per month (PMPM) payment system. Participating SBHCs could report on integration measures in return for increased PMPM payments. These payments could help support provision of fully integrated behavioral health services for SBHC members. Such payments would allow some SBHCs to expand their behavioral health services and increase the integration of these services.

"It would be amazing," said one SBHC administrator about this proposal. Another said, "That would be great. They would give us more dollars, and we could provide more behavioral health care."

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☒	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☒	☐	
Staff capacity	☒	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☒	☐	
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

School-based health centers provide integrated, whole-person physical and behavioral health care. A clinic providing such care should include these characteristics:

Staffing

- One or more primary care provider, including a nurse practitioner, physician assistant, or physician
- One or more master's level social worker or licensed therapist/counselor

Depending on capacity, clinics should also staff health educators, outreach and enrollment specialists, patient navigators/care coordinators, and case managers. Many of these roles in small school-based health centers are filled by a single person.

Integrated care providers should also have policies and procedures in place for the following:

- Co-location of services
- Communication and coordination of data, team meetings, scheduling
- Integration of electronic health records to the greatest extent possible
- Patient tracking across clinic providers
- Coordinated referral of patients to other community resources, including nutrition support, specialist care,
- Case management/patient navigation/care coordination
- Some kind of tracking and coding system for behavioral health, aligned with and/or integrated into clinic system tracking and coding physical health

As one SBHC provider described, "In order to say you have integrated care, you need to have behavioral and medical health *living together*. They need to be able to see patients together when appropriate, have shared responsibility, and good communication. Everyone's on an equal playing field. No one holds all the cards."

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

The care coordinator position at an SBHC is essential to providing fully integrated health care for vulnerable patients.

SBHCs define care coordination as the activities of the person who helps patients and their families navigate health care and wellness services, and who helps them stay compliant with treatment plans. When data show that a patient needs intervention out of the clinic, the care coordinator is the person who conducts that intervention. One provider said, "Care coordination is the centerpiece of all the services we provide. The care coordinator is the position that ties everything down."

Some providers felt that while the RCCO should support care coordination by providing trainings, data, and resources, the person doing that work should be located in each clinic, fully integrated into all the clinic's services and information systems. It's crucial for a care coordinator to have personal relationships with each patient and her family. If a patient misses an appointment outside the clinic, or is having difficulty adhering to a treatment plan, the care coordinator can draw on a personal relationship to support that patient through change.

The care coordination role is also central to each clinic's work saving on health care costs overall. The care coordinator can take charge of reducing a patient's unnecessary emergency department visits, for example. The care coordinator is the person who is able to look at the larger issues facing each patient, including home and school or work environments, and provide targeted wellness support across disciplines and agencies.

While recognizing the potential for confusion of the care coordinator role across the RCCO system, CASBHC believes that this role is essential to the optimal function of an integrated health care clinic like an SBHC. The care coordinator working at each SBHC is part of its processes and systems and can best take charge of the aspects of a patient's care that must happen outside of the exam room.

Some of the SBHCs are officially taking on care coordinator responsibilities, along with the associated extra tracking responsibilities, so that they receive additional reimbursements by the ACC program. Some SBHCs do not have the capacity for the administrative burdens associated with this enhanced PCMP status. However, CASBHC urges the ACC staff to consider ways to reimburse all patient navigators and care coordinators at SBHCs.

b. How should RCCOs prioritize who receives care coordination first?

Most of SBHC providers believe that care coordination is most important for patients with multiple diagnoses, chronic conditions, or special high needs circumstances, including refugee or asylum

status. It's also important for people with language and cultural differences, because these families need additional support navigating the health care system.

c. How should RCCOs identify clients and families who need care coordination?

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role?	Should the RCCOs coordinate with community	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?

	Yes	No	supports and services? Yes	
Abuse, neglect, and trauma	☒	☐	☒	
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☒	☐	☒	
Health literacy	☒	☐	☒	
Housing	☐	☐	☐	
Language or translation services	☒	☐	☒	
Literacy	☐	☐	☐	
Transportation	☒	☐	☒	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved. RCCOs should coordinate dental care on a systems level and support clinics with data and resources about regional dental providers.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Please type your response here. Everyone who touches a patient should have some responsibility to ensure that that patient has access to all the resources she or he needs to get and stay healthy. This responsibility could consist of communication and data-sharing with the care coordinator. The care coordinator should be in regular contact with all providers and be tied into the clinic's electronic health records system to		

optimize tracking and communications. SBHC providers, however, feel that care coordination is a complex enough position that providers do not have the resources to take that on adequately.

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

SBHC providers agreed that care coordination in their clinics costs significantly more than $8-$9, but could not provide a number. A small number of high-using patients cost a great deal to support. Many SBHCs have remaining unmet needs for care coordination. An increased reimbursement for that service could help meet the need for those services.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

Patients with more than three diagnoses or with chronic disease warrant an increased PMPM for care coordination.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

When patients are resistant to changing their habits, their outcomes may not improve. The department could measure assessments, referrals, and follow-up visits. Some SBHCs use decreasing emergency department and hospital admissions as an outcome. If care coordination decreases preventable hospital admissions, that's an indicator that care coordination has been effective.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

RCCO maps should match BHOs to enable full integration of care, full coordination of services, and the least administrative burden on clinics.

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

Haidith: beyond being more supportive of bilingual providers, any language. Very important to train staff for them to be away of cultural differences, be mindful of how to reach higher needs populations (esp of newcomers to country). They will not be successful if they don't have skills. Training. They should conduct trainings—they know the immigrant communities. Training in all the countries where there are immigrant populations. Supporting the medical practices that do that work—hard to attract good providers in rural areas. How will they learn it if they are in crisis mode all of the time.

Cultural diversity within Latina population. A lot of diversity: another challenge. Cultural training has to talk about differences within Central and South America.

LB: to be able to provide access to training, education opportunities. Our staff does not have enough training. We've been entrenched in our own way of seeing the world and its' hard for individuals to step out of their own lens. We have such a diverse patient population. The number one thing is to have health staff to take a breath and set judgments aside, and that's not easy in a very fast-paced, numbers-driven system. The RCCO would be the place--where are all the resources for these various populations. It's not just ethnicity, socio-economic populations, LGBTQ, single parents, a lot.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

ACC shouldn't reimburse emergency room doctors at higher rates for non-emergency services.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☐
Care management tool	☐	☐	☐	☐	☐
Care transitions alerts	☐	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☐
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

81) How can Health Information Technology support Behavioral Health Integration?

Most SBHCs are collaborations of at least two health care providers—the medical sponsor and the behavioral health provider—as well as any dental providers, health educators, or others. All entities have different EHRs, and their EHRs are typically incompatible with each other. Providers cannot legally share patient information across disciplines when they are employed by different entities unless they have specific privacy protocols in place. When their privacy procedures enable such sharing, their incompatible EHRs make that sharing difficult.

However, some cultural differences between physical and behavioral health care providers are also relevant. Behavioral health providers typically do not "code" encounters in the same way that medical providers do. Their patient records are confidential, to best treat their patients. Medical providers can be frustrated by the lack of data generated by behavioral health care providers. And behavioral health

providers may be frustrated by any demands that they change their patient record practices in ways that do not suit the nature of mental health work.

These cultural and technological incompatibilities have broad effects on SBHCs. Patients do not receive the optimal care when their providers cannot share information about each patient. SBHCs cannot track behavioral health encounters and cannot incorporate behavioral health data into their ongoing quality improvement efforts. Some SBHCs use double or triple entry of patient information to supplement their patient records with behavioral health information. More commonly, they accommodate the IT gaps using inefficient and transitory in-person communications.

Efforts such as CORHIO, to align separate EHRs and increase compatibility, will only work if all providers participate. Currently, some SBHCs cannot get any information about patient hospital visits if patients go to certain hospital systems. Furthermore, CORHIO does not help solve the different IT and cultural systems that physical and behavioral health providers use.

Some SBHCs with strong behavioral health integration employ internal tracking codes for behavioral health. They use these codes in their ongoing quality improvement efforts. They could be models for a broader system of using IT and internal tracking processes to better integrate behavioral health care into the SBHC practice.

Any adjustment to behavioral health IT must accommodate a clinic's need to track data with the behavioral health provider's need to preserve patient confidentiality.

Ultimately, however, these incompatibilities point to the broader difficulties that the Medicaid carve-out has imposed on integrated health care clinics. When behavioral health providers can be employed by the integrated clinic, incorporated into their protocols, processes and IT systems and reimbursed by Medicaid for treating Medicaid-covered patients, they can provide fully integrated care. When behavioral health providers are employed by outside entities and try to integrate into an SBHC, the financial, technological, and cultural barriers make full integration extremely challenging.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

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Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Kristen Pieper
Location: Denver, Denver, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Covering Kids and Families
Location: Denver, Denver, CO
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocacy organization

Are you currently involved in the ACC program?

☐ Yes
☒ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

The Colorado Covering Kids and Families (CKF) mission is to increase access to affordable health coverage and high quality health care by ensuring that Medicaid, Child Health Plan Plus (CHP+), and subsidized private insurance through Colorado's state-based marketplace consistently meet the needs of low-income Coloradans. CKF works to ensure that eligible Coloradans are enrolled in Medicaid, CHP+, and subsidized private insurance through Colorado's state-based marketplace by coordinating and improving outreach efforts; identify the successes, challenges, and barriers low-income Coloradans face in enrolling in and retaining affordable health coverage and accessing health care services; and propose solutions that simplify, streamline, and coordinate affordable health coverage programs by maintaining strong relationships with the Colorado Department of Health Care Policy and Financing, Colorado's state-based marketplace, and other relevant entities.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely

☐ Since before the program was implemented.

☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?
2) What is not working well in the ACC Program?
3) What is working best in the Behavioral Health Organization (BHO) system right now?
4) What is not working well in the BHO system?
5) What is working well with RCCO and BHO collaboration right now?
6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

The focus of the ACC should be on prevention and health promotion, not just intervention. Investing in preventive health care, both physical and behavioral, among children is a surefire way to decrease the development of chronic disease in the adult population, which will lead to lower health care costs.

Payment systems and contracts for behavioral and physical health must reimburse for preventive efforts. The current behavioral health payment system is designed to respond to individuals with behavioral health diagnoses only, as opposed to paying for early psychosocial and behavioral intervention for individuals and families with risk factors. Behavioral health prevention and health promotion efforts are critically important to cost effective, patient-centered care.

Care Coordination

11) Care coordination is an important part of the ACC Program.

   a. What is the best definition of care coordination?

   b. How should RCCOs prioritize who receives care coordination first?

   c. How should RCCOs identify clients and families who need care coordination?

   d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

   a. What care coordination is going on today?

   b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

   c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

   d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

The areas identified in the table below are functions that the organization providing care coordination, whether it is the RCCO or PCMP through a care delegation agreement, should be providing.

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☐	
Affordability (assistance with	☐	☐	☐	

prescriptions or co-pays)				
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	
Health literacy	☐	☐	☐	
Housing	☐	☐	☐	
Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	
Transportation	☐	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Care coordination models should not be dictated by the state or RCCO. Focus should be placed on the outcomes desired, not on restricting or defining the providers or provider team. RCCOs and PCMPs with care coordination delegation should have the flexibility to create a system that works for their population in achieving those outcomes.

Type:	**Coordinate care?** Yes	No	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	

Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

The ACC should promote comprehensive care, including physical, behavioral, and oral health services, that is integrated or coordinated and easy for families to navigate.

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	

Other populations, please comment: The ACC Program should recognize and address the complex care coordination needs of individuals with limited English proficiency, non-Spanish speaking immigrants, and newly arrived immigrant families unfamiliar with the health care system.

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

RCCOs should connect with and complement existing resources that support children today. There should not be duplication or replacement of existing structures.

19) How should care coordination be evaluated? How should its outcomes be measured?

Key Performance Indicators (KPIs) should continue to be used to evaluate outcomes. However, as evaluation and measurement continue to be topics of discussion, it is important to recognize that measuring pediatric priorities such as prevention, early identification, and early intervention will look very different from measuring adult priorities such as chronic disease management. Children have health care needs that are very different from adults and represent a significant enough portion of the Medicaid ACC population that evaluation models should be differentiated for children.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐

More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

The Department should continue to utilize KPIs to demonstrate the effectiveness of care coordination.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Whole family care is important, particularly for pregnant women and young children.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

In order for patient-designated attribution to work better, Health*Colorodo*'s contract should include the following:

- Funding and accountability to assure efficient and accurate patient-designated attribution.
- The ability for clients to designate their PCMP on the Medicaid application, both on paper and through PEAK.
- Ability for all Medicaid clients, new and those previously enrolled, to submit PCMP selection and changes through a fax or online form, which receives a confirmation receipt for both the patient and selected PCMP.
- Appropriate call center staffing levels to minimize wait times to less than five minutes and a system implemented which allows patients to leave a number and be called back by a representative rather than remaining on hold.

The following waivers or State Plan Amendments (SPA) should be sought from the Centers for Medicare & Medicaid Services:

- SPA to utilize projected annual income for Medicaid and CHP+ determinations.
- Waiver to allow 12-month continuous eligibility for Medicaid and CHP+ adults in order to mitigate churn.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

Case management is not included in the benefit structure, though it is often provided by PCMPs and reduces the overall cost of care. Adding case management to covered benefits would allow expansion of the service, ultimately decreasing the overall cost of caring for the population.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

The state should take advantage of the state option to use projected annual income instead of monthly income for Medicaid and CHP+ so that income determinations are better aligned with marketplace income determinations. In addition, Medicaid and CHP+ adults should receive 12-month continuous eligibility. These two policies will reduce churn between programs and increase continuity of care for patients.

Until the necessary alignments can be accomplished, the ACC Program and Connect for Health Colorado should work closely to ensure that patients with eligibility changes and movement between programs have consistent access to primary care.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

RCCOs should have a uniform governance structure, which requires at least two consumer representatives. These representatives should be clients, client family members, or client advocates.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

See response to question 39.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

See response to question 39.

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

RCCOs should have community advisory boards that include representation from SEPs, CCBs, counties, local public health agencies, and other community-based organizations and nonprofits.

g. What role should counties play in the next iteration of the ACC Program?

See response to question 44f. In addition, many counties have existing Healthy Communities programs which help families understand their benefits and access care. The next iteration of the ACC Program should intentionally incorporate the expertise and resources that county Healthy Communities programs have developed, and build on the relationship with Healthy Communities for improved coordination.

h. What role should local public health agencies play in the next iteration of the ACC Program?

See response to question 44f.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

See response to question 44f.

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

The functions described should be included in each region's care coordination approach, but the specifics of job titles and the mix of providers should not be prescriptive. The focus should be on developing locally appropriate systems that fulfil the functions and meet identified outcomes.

47) **Community Health Worker reimbursement**. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

The National Committee for Quality Assurance defines cultural competency as not only having empathy, but expressing it toward patients regardless of the patient or provider's cultural background. In order to do so, clinical and non-clinical staff must have an adequate understanding of their patient population, including its diversity, health literacy, language needs, etc. With understanding of the patient population, providers are encouraged to utilize motivational interviewing as a technique to facilitate culturally competent conversations.

b. What RCCO requirements would ensure cultural competency?

All clinical staff should be trained in motivational interviewing and enroll in cultural competency trainings with continual follow up, both of which RCCOs can provide or facilitate connections to. RCCOs should also require practices to determine cultural competency standards and hold them accountable for training staff about and meeting those standards.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

See responses to questions 49a and 49b.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Bilingual or translation services, onsite staff with expertise in cultural competency, and ensuring that every patient completes a health literacy assessment are factors that contribute to enhanced cultural competency. In addition, RCCOs should develop educational materials and resources for individuals with limited English proficiency, non-Spanish speaking immigrants, and newly arrived immigrant families.

Lastly, skills learned during trainings would incorporate the ability to refrain from making assumptions and would ideally educate participants on what it means to have implicit and explicit biases.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

The specialist network for Medicaid patients is highly limited. RCCOs should have the authority and charge to develop incentives to encourage specialist participation.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☒	This tool is not used for patient satisfaction; it is primarily a patient education tool.
Focus groups	☐	☐	
Other	The state should focus on patient satisfaction tools, not patient education tools, to measure client experience. Tools should not be prescriptive or require practices to duplicate efforts.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other: Community-based organizations that help individuals and families apply for, understand, and use public assistance benefits frequently report that Medicaid and CHP+ clients would benefit from text message and email communication capabilities.		

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 100

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Platte Valley Medical Center (PVMC)
Location: Brighton, Adams County, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Click here to enter text.
Location:
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Hospital and hospital owned clinics
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☒ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:

- PVMC and its clinics are contracted with the RCCOs.
- PVMC also works closely with providers such as Salud on care coordination and transitions of care initiatives.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

PVMC and its clinics are enrolled in Medicaid and treat Medicaid members. PVMC is also a CAAS site so it assists indigent patients in enrolling in Medicaid.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☒ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- The program links patients (clients) up with a PCP that can provide the necessary follow-up care should the patient present in the ED.
- Although not the catalyst for this process, the ACC Program provided an additional incentive for PVMC to work more closely and creatively with Salud and other providers on transitions- of- care initiatives which has been a key driver of reducing length of stay and readmissions at PVMC.

2) What is not working well in the ACC Program?

- Patients may be assigned to a PCP they have never seen;
- The PMPM is not adequate to compensate PCPs for the resources needed or the time spent to manage and improve care, lower costs and meet KPIs;
- Eligibility data is not always accurate.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

- The fee schedules offered by BHOs do not cover the cost of services;
- BHOs operate M-F, 8-5 leaving hospitals with no access to case management to obtain the required authorizations or to request assistance with placements/transfers.
- BHO network is not adequate in the PVMC market; there are few providers willing to accept Medicaid patients or provide psych consults in the hospital;
- BHOs have no financial accountability;
- There's no standardization of processes, forms, requirements across BHOs;
- Eligibility information is often outdated; clients are assigned BHOs based on county of residence but clients often move frequently or live in areas where it's easier to access care in another County. The current system doesn't account for our increasingly mobile society.

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

- Claims processing is hampered or delayed when the RCCO and BHO are not the same entity. Claims that are coded with co-occurring physical/behavioral health conditions often get held up and require more work to get paid. If the claim has a primary Dx of a medical condition but there are secondary or tertiary behavioral health codes on the claims, the RCCO may deny citing BHO responsibility; then the BHO will deny since the primary Dx is medical.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

- An integrated RCCO must be financially accountable and transparent to ensure clients receive all the appropriate care they need.
    - A medical loss ratio (MLR) requirement similar to what the ACA enacted for commercial payers would be ideal; including yearly publication of the RCCO's MLR.
    - A mechanism for establishing and evaluating the RCCO on the basis of quality similar to NCQA accreditation would also provide accountability and transparency and allow for an objective comparison among the RCCOs.
- Require RCCOs - especially for behavioral health services - to operate during the same business hours that they require providers to complete auths and transfers; or limit the penalties they are allowed to hand down-if the RCCO does not operate extended hours.
- Standardize all required forms and reporting requirements instead of allowing each RCCO to develop its own.
- Develop or require RCCOs to develop, resources for hard-to place clients such as those with a history of violence.
- Patient accountability and engagement strategies should be built into the RCCO requirements. PVMC implemented incentives with its own employees which is helping to reduce its health insurance expenditures.
- Require the RCCO to have the necessary IT infrastructure to:
    - Satisfy all HIPAA electronic transaction requirements (in force now and as may be developed; also be ICD10 complaint);
    - Offer an electronic patient portal;
    - Provide providers with an electronic means of benefits/eligibility checking; on-line pre-certs, and claims submission/status checking instead of relaying on telephonic systems.
    - Have the necessary analytics and reporting systems in place to support any performance-based contract with providers

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

b. How should RCCOs prioritize who receives care coordination first?

- Data should be analyzed as it will likely show that the higher-acuity patients utilize more resources and therefore, they should be targeted for priority in receiving care coordination. The analysis should reflect both medical and behavioral health services used; diagnosis, co-morbidities, and demographics.
- The data can be used to construct risk tiers that equate to level of priority.

c. How should RCCOs identify clients and families who need care coordination?

- Delegated care coordination - allow providers to identify who needs care coordination using the criteria established through the process under (b) but the RCCO should also allow room for flexibility based on the provider's judgment as they will have access to new information that may not be reflected in the existing claims data for that client.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

- Whatever the decision, it should be a standardized process, preferably electronic.

12) What services should be coordinated and are there services that should not be a part of care coordination?

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	
Health literacy	☐	☐	☐	
Housing	☐	☐	☐	
Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	

Transportation	☐	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	

Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

   a. What is the PMPM cost for providing care coordination services?

   b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

   a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

- For hospitals, quality metrics around length of stay, HCAPS, readmissions and/or other nationally recognized metrics should be used. Using nationally recognized metrics/standards would also afford the Department comparable data.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

- Providers must be part of the conversation and include in decision-making around metrics and processes for care-coordination. Often the RCCOs/BHOs make determinations based on proprietary (sometimes retrospective rather than current) info/data and without knowledge of the day- to- day challenges providers face which make compliance with their requirements unrealistic at times.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

- RCCOs and BHOs must be required to have systems that comply with HIPAA transaction requirements and commercial payer industry standards around use of portals, real-time legibility and pre-cert information so that they can electronically interface with providers who have that ability.
- Rules should not prevent innovation among and between providers or RCCOs/BHOs who have the desire to pursue electronic integration to facilitate transitions of care and care coordination.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

- Yes, RCCOs should compete like any other commercial payer. Clients should be allowed to choose and change plans based on the RCCOs performance rather than geographic area just like Medicare allows its beneficiaries to do.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

- The RCCOs should have primary responsibility for stakeholder engagement and encouraging it among providers.
    - To help guide its efforts the RCCO may want to adopt a guiding philosophy such as the Planetree model. Planetree promotes patient-centered care through combining evidenced-based medicine, complementary healing arts, family engagement and education/information.
- RCCOs should develop communication strategies and resources for families including assisting with providing translators if necessary. The Medicare program offers some good examples – it provides numerous free brochures and checklists; an interactive patient-centered web site, and local counselors who work with community organizations to educate its beneficiaries.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

- RCCOs should be required to provide resources that help stakeholders connect to one another or to facilitate access to each other; they should not rely on paper resources but should also adopt technology as well as regular face-to-face meetings.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

- Behavioral health, specialists

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

- Hospitals can assist with: identifying which needs are unmet for the Medicaid members in its community; where resources should be focused; and what provider types are most needed.
- Many PCPs are employed by hospitals so the ability to influence quality and cost-effective care is greatly increased by involving hospitals and including them in PCP incentive discussions.
- Hospitals also are extremely active in their communities so better know how to engage community stakeholders as well as know where gaps are. Many also already have active patient committees (i.e. the Patient's Voice/Council at PVMC) that could be utilized.

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☒
On staff (salary) at Primary Care Medical Provider Clinic	☒
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

- Require RCCOs to develop strategies to educate its clients about appropriate ER utilization and alternatives; develop incentives/penalties to reinforce patient responsibility such as increased copays for using the ER for a diagnosis that could be treated in a PCP office or urgent care setting.
- Engage physicians and hospitals in developing incentives that offset the losses hospitals would incur for reduced ER volumes and encourage more collaboration with local physicians. Incenting physicians only will not lower utilization.
- The ACC must recognize that hospitals have EMTALA obligations and they should not be penalized for following the law.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	

10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☒
Digital care management tool	☒	☐
Care transitions alerts	☒	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☐	☒
Practice assessment tools	☐	☒
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☒
Telemedicine software	☐	☐
Other: Electronic security software/apps Patient Access software (integrated price-estimator/eligibility/registration system)	☐	☒

Financial Analytics Reporting		
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☒	☐
Care management tool	☐	☐	☐	☒	☐
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☒	☐	☐
Health risk assessment software	☐	☐	☒	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☒
Patient education wellness tools	☐	☐	☐	☒	☐
Provider/case manager directory	☐	☐	☒	☐	☐
Shared decision-making tools	☐	☐	☐	☒	☐
Telemedicine	☒	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

81) How can Health Information Technology support Behavioral Health Integration?

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

- Secure shared access to clinical information would be extremely helpful to hospital providers (primarily ER physicians and hospital case management). However, the ACC Program should strive to develop a "flexible" HIT infrastructure that can integrate with HIT that providers already own as well as serve as the primary tool/resource for those providers who have not yet been able to make the investment. In a time sensitive environment like the hospital ER, if a provider has to get into a separate system or launch a new application, they likely won't use it as it delays care.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 101

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Patrick Gordon
Location: 2775 Crossroads Blvd, Grand Junction, CO 81506

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Rocky Mountain Health Plans
Location: Grand Junction, Mesa County, Colorado

☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☒ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?
X Yes

If you answered "yes" above, how long?
X Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Rocky Mountain Health Plans (RMHP) is very honored to serve as the RCCO for ACC Region 1.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
RMHP has supported the Colorado Medicaid program continuously since 1974. RMHP has supported Medicaid through a variety of contractual agreements, but our mission and strategy have been consistent: the creation of equity in a community system of health through the alignment of local leadership and resources. The ACC is structured on these principles and will produce results if it continues to adhere to them.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?
X Very likely
☐ Likely

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

Flexibility. Community leadership and accountability. A focus on outcomes rather than process. A very smart approach that is producing a powerful statewide network with limited, per capita investment.

2) What is not working well in the ACC Program?

Ongoing instability in budgeting and core operational functions. No specific targets for enrollment growth. No specific, prospective budget targets, cost accountability or shared savings framework for ACC participants.

What is working best in the Behavioral Health Organization (BHO) system right now?

A statewide network of safety-net providers is well sustained and healthy enough to contemplate a broader role in a community system of health.

3) What is not working well in the BHO system?

Capitated payments are still tied to volume-based encounter reporting, which significantly limit integration, community-oriented interventions and supports.

4) What is working well with RCCO and BHO collaboration right now?

There is significant progress toward shared prioritization, data sharing, gap closing between primary care providers and mental health centers, and measured performance. Advancements in all of these areas has been accelerated within the HB 12-1281 pilot through the creation of a global budget, a full risk transfer, distribution cost accountability and specific, transparent shared savings mechanisms.

5) What is not working well with RCCO and BHO collaboration right now?

The payment model for providers and programs in both systems is still based upon encounter volume.

Behavioral Health Integration

6) What should be the next steps in behavioral health integration in Colorado?[1]

Enhance payments directly to PCMPs, so that they can recruit, employ and integrate behavioral health providers within their own organizations and care teams. Likewise, PCMPs could contract externally for such services, if they choose to do so. The new payments should be made on a per member, per month basis, in the same manner that has been established for care coordination – not through a FFS process by 'turning on codes'. A payment increase of $1-$2 pmpm would make a very meaningful impact, in the very near term, in high volume Medicaid PCMP settings, for a large segment of the Medicaid population.

Accountability for the increased funding could be tied to 1) achievement of PCMP milestones of development within the entire model (e.g., Comprehensive Primary Care milestones), and 2) submission of a credible staff integration plan by the PCMP.

Likewise, to the extent that the implementation of these payments are linked to the promotion of multi-payer initiative in positive State action (e.g., SIM), substantial integration can occur (over a longer period of time) in PCMP settings where Medicaid is a smaller share of the payer mix.

This approach is the fastest and most actuarially-defensible path to creating the broadest possible impact in a short period of time.

We believe that a targeted increase to qualifying PCMPs can stand upon its own from a return on investment standpoint, but if need be, could be financed on a budget neutral basis through a redistribution of current RCCO payments, incentive funding and PCMP payments to lower tier practices.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

7) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	X	☐	The CMHCs may largely be "subcapitated" or reimbursed on a "percentage of premium" basis, but the BHO capitation itself method is still very much tied to encounter volume. Additionally, the underlying budget structure still largely reflects the utilization of services for the 'SPMI' population, which limits overall resources available for a broader array of community-based integration activities. (No changes should be made that compromise the existence of a functional safety net for this population.) Short of simply ending the carve out, the latter problem can be addressed through better, more closely structured partnerships among CMHCs, RCCOs and PCMPs (which are, in some cases, developing naturally with enlightened support from BHOs). The Department has tremendous leverage in this area and can take steps to promote functional partnerships. The former problem will likely necessitate reform at the federal level. Much to our disappointment, recent waivers to allow "alternative payment methods" may not be sufficient, as recent CMS communications with other states (e.g., Oregon) indicate. Collective, sustained action, advocacy, discipline, 'risk taking' and 'envelope pushing' by Colorado leaders will be necessary to push federal policy and state legacy operations from the current "volume-based capitation" model to authentic, value based budgeting and payment. Health information technology and data exchange creates many opportunities to measure productivity and the impact of population management activities *without* the need to generate a CPT-based, MMIS-adjudicated "encounter claim". There is much we can do to move

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

			forward, now, but we are going to need to push for sweeping modernization of CMS' Medicaid payment policies and our own state operating systems.
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	This is an artifact of the behavioral health carve out, which perpetuates a 'diagnosis-centric' mode of organization and service delivery. Short of simply ending the carve out, the creation of a regional global budget with shared cost accountability (or full risk where possible) for both the RCCO and BHO will shift the focus quickly from diagnoses to outcomes.
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☒	☐	"If it can't be coded and billed, it can't be sustained." Increases in primary care reimbursement are essential for the integration of behavioral health services. The form of reimbursement matters greatly, as well. "Turning on codes" will be a much less efficient use of the increased funding for the integration of behavioral health services than a non-volume, non-CPT, non-Dx oriented payment model. Relatively small pmpm payments to PCMPs for integrated behavioral health services could be a much more effective means of moving forward with BH integration (much like small pmpm payments within the ACC have been an effective means of moving forward to create a better statewide framework for care management). Small pmpm payments for BH services in primary care settings are readily justified with actuarial analysis. Moreover, to the extent new Medicaid payments are linked to broader state policies that promote multi-payer alignment, commensurate resources for BH integration will become available in settings with lower Medicaid volume – thereby maximizing the capacity for comprehensive primary care services statewide.

Per-member per-month amount	☐	☒	Big things can be accomplished with small PMPM payments – provided that substantial flexibility is maintained in how RCCOs, PCMPs, CMHCs and any other organization can use them to achieve state policy objectives and improvement targets. Big payments won't necessarily accelerate productive change or make those changes that do occur sustainable. Small payments with limited flexibility serve no purpose.
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☒	☐	There is a substantial opportunity in this area to distinguish the actual from perceived barriers – particularly regarding 42 CFR. We don't need to wait for SAMHSA. Proactive clarifications with the State's imprimatur about what information (in specific situations) is subject to 42 CFR protections, and which information is not, would be a low-cost, low-risk means of accelerating productive information sharing for more effective, better targeted, interventions and care coordination activities within the ACC.
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☒	☐	A single contract for both scopes of services should be implemented – either with a single entity or a contractually integrated partnership.
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

8) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

These are generally evident in the core functions and competencies of comprehensive primary care. These characteristics include, but are not limited to: Active empanelment, prioritization and targeting processes, a focus on team based processes and competence with data driven process improvements; a willingness to develop and expand "non-encounter" oriented patient outreach, intervention and follow-up processes; the active use of patent and family feedback channels (e.g., "PFAC" processes) in addition to traditional "survey" approaches; and the inclusion of behavioral health providers on equal footing and in all team based processes – in the same manner that other "new" resources are included (e.g., care managers).

9) Please share any other general advice or suggestions you may have about behavioral health integration.

Behavioral health integration entails a wide scope of activities across a diverse range of needs within the population. That said, the most immediate opportunity in this area is tied to the development and expansion of the comprehensive primary care model. All elements of that model must be supported and optimized in order for investments in integrated behavioral health to generate returns – particularly the core concept of *teom bosed care*. Code based / CPT revenue oriented models may "sustain" the behavioral health clinician in these settings, but have limited impact if the role of the clinician is circumscribed by the scope of code-able activities. We are seeking *integrotion*, not FFS-driven co-location in this model.

The same can be true in some cases regarding "embedding" arrangements, in which the behavioral health provider functions as an employee of an external organization. Circumstances vary from site to site, but one is generally less likely to be included as a "team member" when his or her organizational accountability exists outside the clinic walls. The same phenomenon has occurred in traditional managed care settings, in which health plan "care managers" are embedded by an external third party in primary care settings.

To the greatest extent possible, primary care providers should have an opportunity to "own" their own personnel – as well as the measured outcomes they produce.

The same principle applies to the integration of primary care providers in mental health settings.

Aside from how the team is organized and operates within a primary setting, the integration of community services *outside the clinic wolls* is a tremendously important factor in the success of the model. Community integration is where CMHCs and numerous other entities have an opportunity to lead entirely new interventions that generate better outcomes – in addition to their ongoing role as a safety-net for the provision of specialty services (which can also be much more tightly integrated with primary care).

Community integration will occur fastest if and where: 1) specific global budget, cost accountability and shared savings targets are established, and 2) the Department works intentionally to create opportunities that are contingent upon demonstrable, authentic collaboration among Medicaid stakeholders – particularly traditional safety net interest groups.

Partnerships cannot be mandated. Rather, the Department should create opportunities for more advanced models and greater flexibility by 'testing integration' – i.e., written agreements with teeth and inclusive governance = new opportunities.

The ACC is not a zero sum game based upon "win/lose" decisions about where services are best provided or who should have an exclusive license to provide them.

Care Coordination

10) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

A comprehensive network, comprised of and sustained primarily through existing family and community resources, which wraps around in a timely, targeted manner to address the social, behavioral, cognitive, functional and health care needs of an individual.

"Care coordination" is not about hiring staff and attempting to perfect the ratio of 'managers' to clients. Care coordination about closing gaps and the creating an effective network of supports in each unique community.

b. How should RCCOs prioritize who receives care coordination first?

There are two, primary modes for care coordination: *longitudinol* and *episodic*. RCCOs (and any other entity engaged in 'care coordination' as a community process, defined above) must exchange and utilize wide array of quantitative and qualitative information to *respond* in a timely manner to the needs of clients when they arise – from "cold-spotters" and "non-utilizers" to highly vulnerable individuals with complex needs.

Longitudinal care coordination tends to focus on well-identified clients who require more extensive support, but care coordination activities for this population can also often be episodic in nature when circumstances change.

Less complex or "healthy" individuals require substantially less ongoing support, but community care coordination systems must still account for social and behavioral risk factors, and also respond rapidly to changes or events that create immediate or longer-term risks. For example, the "normal delivery" of a newborn by a young mother will not necessarily occur as a priority in a traditional "complex care management program", but nonetheless necessitates follow-up, coordination with community resources (e.g., nurse-family partnership) – as well as a comprehensive assessment of family needs and risks that are not evident in health care data about the new mom.

Accordingly, "prioritization" of care coordination activity occurs along two tracks within this model: *risk criteria* and *event triggers*, and must be supported with a process for comprehensive client risk assessment. Below is a high level summary of the risk factors that are essential in the identification of client needs and prioritization of care coordination activities:

- Cultural, linguistic, visual and hearing needs, preferences or limitations
- Health status and clinical history
- Substance use / abuse
- Activities of daily living
- Housing and/or caregiver status
- Mental health status and

- Cognitive function
- End of life preferences and planning
- Access to benefits and community resources
- Barriers to the fulfillment of an agreed care plan

Additionally, care coordination activities can be triggered by a wide array of encounters and transitions, which include (but are not limited to):

- Facility admissions and discharges
- Community-based transitions of care
- Eligibility changes and transitions
- Chronic and catastrophic disease diagnosis and progression

The resources present within any single organization (RCCO, PCMP, Hospital/Health System, LPHA, CMHC, LTSS Provider, BHO, managed care plan, county, CCB, SEP, other) are insufficient to execute this scope of prioritized care coordination on its own – regardless of funding, capital, expertise, sophistication or other attributes.

Community integrotion, in which a network of active communication pathways, prevention and response systems are developed among multiple independent organizations, is the only practical means of executing both the longitudinal and episodic components of an effective care coordination system. Narrow prioritization schemes that focus on a limited number of criteria or risk factors may help a small number of people, but generally contribute to ongoing population segmentation and fragmentation in the delivery of services, and do little to impact overall trends in health and cost.

c. How should RCCOs identify clients and families who need care coordination?

Timely identification and response to client and family needs entails a robust, multi-dimensional system that both incorporates discrete, quantitative data and qualitative, subjective, non-structured information from key sources within an integrated community framework.

The *clients themselves* are most effective source of information about needed care coordination supports. Patient reported data can be captures and structured in many ways, but a *client's own words* are often the most powerful means of prioritizing and organizing care coordination within an integrated community framework.

Of course, effective communication depends upon contact and the creation of a trusting relationship. Where no such relationship exists, there are numerous other means of identifying and initiating care coordination.

The ACC has enabled RCCOs and numerous other partners to access and act upon the essential data that is necessary (but not sufficient) for effective care coordination. This includes, but is not limited to: Client demographics, eligibility status for a variety of programs, location, diagnoses, screening results, health service and pharmacy utilization, client onboarding and ongoing risk assessment data, transition alerts, risk scores, predictive metrics and total costs.

However, qualitative judgments and structured referral processes among community partners are also a powerful means of identifying and responding to client risks. A simple, subjective stratification process can be used by clinical and non-clinical organizations to target community supports – e.g., "when I review my client (or patient) list, I think that it is highly likely that X number of people will be at risk for a" hospitalization, a loss of function, relapse, housing dislocation, etc. There is substantial evidence that qualitative, subjective assessments of risk and stratification techniques have predictive power and compliment methods that utilize administrative and clinical data. A value proposition must be present in order for most community organizations to participate in a community-wide assessment and targeting process, but the Department can play a critical role in setting direction, goals and targets to facilitate this process.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

"Delegation" of a function does not mean "delegation" of ultimate responsibility for care coordination activities and outcomes within a community system of care. It's inconceivable that an accountable entity would "delegate" care coordination responsibility to another entity and then be unable to account for the activities and performance of the delegate.

Likewise, "top down" mandates regarding the use of standardized forms, tools, applications, labor intensive reporting processes, are usually a non-starter at any level, and inconsistent with the imperative to create an engaged community network. Regulation and delegation are two entirely different concepts.

Rather, it is incumbent upon the RCCO to:

- Promote implementation of consistent, comprehensive risk assessment and care planning elements (even though applications and tools vary);
- Facilitate open communication about roles, limitations, overlaps and gaps;
- Utilize the resources and flexibility granted by the Department to fill gaps where necessary;
- Provide the resources and labor necessary to collect and assimilate data from multiple sources and systems among community partners;
- Report care coordination activities and outcomes in a timely, integrated manner;
- Maintain full accountability for every enrolled client and every care coordination interaction, regardless of where it occurs or how it is documented.

In short, the RCCO should track care coordination – and provide all of the support required to do the tracking. RCCOs exist to integrate information from a diverse array of sources and function as the ultimate point of accountability. If RCCOs do not or cannot play these functions, it is unclear why they should exist.

11) What services should be coordinated and are there services that should not be a part of care coordination?

Internal clinical processes do not require coordination by an external entity. Again, "care coordination" is not about the creation of yet another new 'program', but rather a *high functioning community network* of independent clinical and human services organizations. HCPF should focus the *power of networks*, not on staffing ratios, the carving in, carving out or categorical assignment of various care coordination functions

for each individual entity. High functioning RCCOs are in the best position to foster the creation of collaborative networks. RCCOs that simply "staff up to manage care" will have a much more limited impact, and will contribute to the cacophony of fragmented 'care management' activity in already present in most communities.

12) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

The primary objective of care coordination is to promote the fullest possible "patient activation" and "self-management" capacity. Understanding the personal goals and life objectives of a client, organizing and describing the care plan as a means to achieving those goals while maintaining communication and trust are the most important aspects of an effective care coordination relationship.

13) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

A rapid proliferation of new services, provided by a wide array of entities in silos, most which are focused upon a narrow range of transitions within the health care system. This proliferation of activity is not necessarily reducing fragmentation or improving transitions of care.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

The ACC is unique in a few, critically important regards:

1) The ACC is focused upon the vulnerable population that is most in need of support. Other care coordination programs tend to be focused upon "well-funded" populations, for which there is intense competition, an effort to create closer relationships with private insurers and employers, and other, more narrowly-defined corporate objectives.

2) The ACC is intentionally and actively working to create a community basis for care coordination, which is fundamentally distinct from corporate accountable care initiatives and entails a much broader scope of integration objectives – well outside the scope of traditional health care operations.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

Few, if any, other initiatives are focusing on this population, so the Department should frankly not be overly concerned about compounding the fragmentation that exists in other "accountable care " initiatives.

That said, to the extent that capitalized, corporate health care entities (non-profit and for-profit alike) step forward with bona fide, demonstrable commitments to assume *substontiol* responsibility for Medicaid (i.e., one that is financially and operationally commensurate with the *volume* of Medicaid eligibility and *demond for speciolty core ond other services* in the markets they serve), the ACC should afford those organizations greater consideration (and flexibility) in the alignment of program efforts with their individual accountable care initiatives. The lower the

financial and operational commitment by these systems to Medicaid, the less consideration should be given to them in program design and operations. A high bar should be set for corporate health care systems in this area.

A high bar should also be set for safety-net organizations and related entities that focus primarily on Medicaid. Failure to collaborate effectively among these entities is not acceptable. Demonstrable community integration among diverse, independent, Medicaid-oriented organizations should be a condition of receiving greater flexibility (and resources) within the ACC. Effective partnerships greatly reduce the potential for duplication and are necessary to achieve the objectives of the program. Where such partnerships don't exist or evolve within the ACC, the Department can impose more "standardization" from the top down to sort things out itself.

d. What are the gaps in care coordination across the continuum of care?

There are more people in need than can be served through traditional 'care management' models – at any level of funding or staffing, or through any corporate process.

There is a growing level of insight and evidence that a community process, in which an agreed, multi-party framework accounts for the social, functional and behavioral needs of individuals, can reverse the underlying drivers of adverse health and cost trends.

It is not possible for the Department (or any other system) to accelerate this process through the imposition of mandated forms, 'protocols', IT applications across multiple independent organizations – all of which operate on their own platforms and will continue to do so. RCCOs must themselves close the gaps and gulfs and work over the walls between systems for Medicaid clients.

The biggest gaps in resources, population impact and alignment of interventions with the underlying drivers of outcomes and costs can be closed if the Department focuses on the promotion of community networks and functional partnerships for information sharing, prioritization, loop closure and trusting, and effective communication with clients.

14) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	**Should the RCCO have a role?** Yes	No	**Should the RCCOs coordinate with community supports and services?** Yes	**Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?**
Abuse, neglect, and trauma	☐	☐	☒	
Affordability (assistance with	☐	☐	☒	

prescriptions or co-pays)				
Daycare / childcare	☐	☐	☒	
Economic stability & employment	☐	☐	☒	
Education	☐	☐	☒	
Environment	☐	☐	☒	
Food access / nutrition	☐	☐	☒	
Health literacy	☐	☐	☒	
Housing	☐	☐	☒	
Language or translation services	☒	☐	☐	
Literacy	☐	☐	☒	
Transportation	☒	☐	☐	
Other	All of these elements are essential to the success of the ACC. Coordination is achieved through integration of multiple services – not reshuffling duties, roles or budgets among various agencies.			

15) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	**Coordinate care?** Yes	No	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☒	☐	
Certified Addiction Councilors	☒	☐	
Certified Nurse Midwives	☒	☐	
Community Health Workers	☒	☐	

Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☒	☐	
Licensed Mental Health Counselors	☒	☐	
Licensed Professional Counselor	☒	☐	
Masters of Public Health	☒	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	
Nurse Practitioners	☒	☐	
Patient Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☒	☐	
Psychiatrists	☒	☐	
Psychologists	☒	☐	
Registered Nurses	☒	☐	
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	
Other	This certainly is a comprehensive list of guilds, training, licensure, credentialing programs and new concepts in workforce development...Don't forget clinical pharmacists, though – they create tremendous value on care teams and in integrated systems. None of these disciplines should be excluded or granted special status in a community-based care coordination process. Highly trained and licensed professionals should be put in a position to practice as efficiently as possible. The 'hard part' often is that doing so means "letting go" of several functions that other individuals on the team can perform more efficiently, and "letting in" a wider variety of players in an organizatoinal process. Aptitudes and inter-personal skills often matter much more than training and licensure in a team-based model of care.		

16) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☒	
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☐	☒	
Children involved in the foster care system	☐	☒	
Children with a chronic illness	☐	☒	
Children with a serious emotional disturbance	☐	☒	
Children with medical complexity	☐	☒	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☒	
Transition-age adolescents	☐	☒	
Parents and families	☐	☒	
Pregnant women	☐	☒	
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☐	☒	
Adults with a chronic illness	☐	☒	
Adults with a behavioral health diagnosis or substance use disorder	☐	☒	
Clients involved in the criminal justice system	☐	☒	
Clients with a disability	☐	☒	
Clients in a nursing facility	☐	☒	
Elderly clients	☐	☒	
Frail elderly clients	☐	☒	
Clients in palliative care	☐	☒	
Other populations, please comment: Specialized focus, attention and resources are, of course, necessary in many of these areas. We responded "general" in all of the check boxes above, because the need for specialized focus often devolves into arguments for fragmentation, carve ins, carve outs, exclusivity, special contracts, program patches and funding silos. The ACC in general, and RCCOs in particular, must be accountable for every single client in every single population category enumerated above. Doing so is possible only through the creation of a high functioning, collaborative network.			

17) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

18) How should care coordination be evaluated? How should its outcomes be measured?

Penetration within the target population, rates of contact and follow-up, the comprehensiveness of risk assessment (all behavioral, social, functional and health determinants), client experience and feedback, provider experience and feedback, the extent to which existing community resources are incorporated in a community-based process (rather than a single organization's silo).

19) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

In the current model, at the current volume of enrollment and scale of operations, a good benchmark is about $5-6 total RCCO funding.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

At this level average of funding, we do not believe that significant variation in the rate of reimbursement will produce better outcomes.

20) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☒
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

High functioning, "complex care management" programs can at best handle 50-75 clients per worker at any given time. A carefully managed balance between *longitudinal* and *episodic* client interactions is necessary to make a meaningful impact the most vulnerable populations – even at this low ratio.

Additionally, when the math is done at this staffing ratio, it is clear there is not and will never be enough funding (in the entire system) to maintain a traditional care management system that accounts for all near and long term drivers of outcomes and cost. As such, a *fundomentolly different approoch* to accounting for the entire population is necessary. A *network model*, in which multiple entities align their resources, define their roles and actively divide responsibilities efficiently (e.g., RCCOs and large PCMPs fulfilling broad, preventive "reminder and recall" functions), is the only means by which the stated objectives of the ACC can be achieved.

21) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

This is an area where "the basics" are (fortunately) the most effective means of assessing performance and impact – e.g., --

- How many people have you contacted and touched?
- How many declinations of your services have occurred, and why? Did you follow-up at a later interval?
- How are you targeting your resources and what are your doing to account for the populations that are not "prioritized" or fall outside your "current capacity"?
- Did you account for a discharge in a timely manner? Where you aware of it? If not, why?
- How do you become aware of other transitions, episodes and events, and respond to them?
- How do you anticipate social, program, family, caregiver or other disruptions and risks that can compromise client health, function and happiness?
- Was the "loop closed" on a referral or follow-up item timely? How do you know? Does every partner involved know the outcome?
- Did you update the care plan in a timely manner? How do you know whether a person's goals or circumstances have changed?
- Etc.

The current RCCO contract and "MME Addendum" are appropriately focused in these areas – all of which necessitate community integration. We encourage more of the same for the time being.

22) Please share any other general advice or suggestions you have about care coordination in the ACC.

The ACC is an incredibly powerful framework for effective, sustainable improvement within the Colorado Medicaid program.

In order for that to occur, it will need substantial time to evolve. Frequent changes in direction will be counterproductive.

Continue to focus on goals and targets – avoid the temptation to mandate too many processes from the top down.

A focus on core care coordination functions is OK. Elaborate outcome measures are few and far between; conventional process measures have limited utility.

Emphasize collaboration. Discourage stakeholder disputes. Excessive "competition" may be harmful. The ACC is not similar to "Coke vs. Pepsi". Greeley vs. Pueblo a fundamentally different dynamic.

Program Structure

23) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Balance is the key in all of these areas.

Standardization can create efficiency and quality.

Standardization also can stifle creativity, impede innovation and problem solving, and result in requirements that are set at the lowest common denominator.

Even if RCCO processes are standardized, clinical processes and platforms will continue to vary significantly, thereby creating the potential for gaps that are counterproductive.

We encourage the Department to walk "a middle path" between the logic of standardization and the power of flexible, community-based solutions. There is a need for both within the program.

The ACC has grown and achieved early wins because the Department has been focused primarily on "the what" – not "the how". We understand how uncomfortable variation can be for a public agency and its stakeholders. We will continue to be accountable as an "assimilator" and community facilitator – both of which are much higher functions than that of a simple "administrator".

24) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Written agreements, with meaningful accountability processes, checks and balances should be required for all "incumbent" organizations – as well as those submitted by longstanding Medicaid interest groups. The deeper the level of financial, data sharing, operational, clinical and community integration present in these arrangements, the higher they should be scored.

New entrants should be evaluated on: 1) the coherence and internal consistency of their proposals to work *outside* the walls of their own organization, with 'aligned partners' *and* competitors alike; 2) their willingness and ability to make capital investments and take on financial commitments that commensurate with the scope and volume of responsibility they propose to assume for Medicaid; 3) demonstrable success in other states and/or other Colorado programs, working within a similar, community-based framework; 4) the scope of and rapidity of impact that they can credibly make within the population.

Documented support from local leaders and key Colorado organizations should be weighted heavily in any scenario. The re-procurement timeline has been extended and is well-telegraphed. Existing contractors and new entrants alike have ample time to make arrangements in advance of the pending RFP.

25) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

We understand why this makes sense to some PCMP groups within the ACC.

There is likely no "conflict free" means of organizing the program.

There is zero sense, however, in any arrangement that results in multiple RCCOs operating within a single county.

26) Should the RCCO region maps change? Why or why not? If so, how?

We understand that there is great interest in aligning the 'BHO' and 'RCCO' maps.

We encourage the Department to focus more upon aligning the BHOs and RCCOs themselves.

Or better, eliminate the carve out policy that divides them.

27) Should the BHO region maps change? Why or why not? If so, how?

A better question is whether BHOs and RCCOs should continue to exist as separate enterprises at all.

Where they do, the best focus is how to promote deeper, more meaningful integration between BHOs, PCMPs, RCCOs and CMHCs.

Redrawing the lines will not be sufficient for that purpose, and may not even be necessary.

Redrawing the lines will (inevitably) cut across some organizational service area, disrupt some corporate zone of influence or market strategy, and make some leadership group unhappy.

Better partnership and community integration can (and must) occur regardless of where HCPF draws lines.

28) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

Transitions should not take more than 6 months.

Transitions among established Medicaid-oriented organizations in Colorado should move faster – the Department should set this expectation.

The 'victor' in such a transition should be responsible all, or nearly all, of the costs of transition – not the taxpayers or the departing entity.

29) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

State statutes generally aren't a barrier, and should be used very, very sparingly.

Department rulemaking is generally a clear, well-communicated and executed process.

Federal regulatory limitations (many of which can be waived) should be the primary focus of barrier busting among Colorado leaders and stakeholder organizations within ACC.

Solutions to fiscal dependence upon hospital fee revenues, which is generated exclusively on a FFS basis, and the 'encounter volume' basis of capitation in traditional Medicaid operations (which also institutionalizes FFS processes) are the two biggest policy barriers to a better ACC.

30) What are the limitations of the current benefit structure and what – if any – changes are needed?

The Medicaid benefit structure is comprehensive in comparison to most others. The problem is access to care that is attributable to differences in payment, the complexities and social disparities of the Medicaid population.

Many people advocate for higher copays on emergency department utilization. Higher copayments might have an impact upon reducing excessive utilization, but will do little to address the underlying social and behavioral drivers that give rise to it. Unpaid balances at hospitals may simply rise.

Some states have attempted to incorporate "responsibility", "personal accountability" and "behavior contract" requirements into their benefit structures. It is unclear that such policies have the intended impact upon behavior, adverse trends in obesity, addiction, depression, or improved self-management of co-morbid conditions. They also do little to address underlying social factors such as housing, nutrition, education, economic opportunity and healthy environments.

Of course, the demographic and demand characteristics of the expansion populations may be different at higher income levels, and some of these changes might be useful as a part of a more comprehensive policy strategy that addresses root causes of poor health and cost within the system.

Beneficiary incentive programs are one area in which state and federal policy changes may make a difference. Incentive programs for physicians and other health care providers are often touted as breakthrough innovations in payment and delivery system reform. Most outcomes are dependent upon decisions and changes made by the patient. Federal policies in this area (for legitimate reasons) severely curtail the scope and design of client incentive programs. Focus by the department upon the development of client incentive programs that are tied to specific, measured outcomes. RMHP has had some success in this area to date; greater focus and policy development would be worthwhile.

31) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

No. If the Department adopts a policy of multiple RCCOs per region, it should simply pursue an expansive, statewide program of mandatory Medicaid managed care.

The only practical difference between a "multi-RCCO-per-region" ACC program and a traditional Medicaid managed care program would be the lack of risk for financial outcomes in the former.

32) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

Not applicable to RMHP in our organizational capacity.

33) What role should RCCOs play in attributing clients to their respective PCMPs?

RCCOs can play a much more substantial role in facilitating and executing the client designation, or "patient choice" process, for PCMPs – in a manner that promotes a much simpler and positive client experience than is entailed through referrals to a third party call center.

RCCOs are designated as "PCCMs" themselves under the State Plan with CMS – in addition to PCMPs.

A documented client choice provided to the RCCO, independently verifiable and auditable, should be sufficient for clients to make *changes* to their PCMP attribution status – in addition to those who request PCMP attribution for the first time.

34) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

Promote closer collaboration between LPHAs, RCCOs and all other ACC participants. The decision item proposed for the SFY 2015-16 budget is a very positive step in the right direction.

The quality of CDPHE relationships with LPHAs will be a critical factor in this area.

RMHP is fortunate to work with very progressive and action oriented LPHA leaders within Region 1.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

Promote closer collaboration between County DHS, ADRC and related programs. We feel that good progress is being made in many counties throughout Region 1.

36) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

There is an opportunity for deeper, intentional collaboration on continuity of care and coverage between C4 programs and the ACC. Proactive outreach to mitigate gaps associated with loss of Medicaid eligibility and "churn" between the programs is underway in pilot programs within Region 1; more can be done to optimize and scale these operations.

37) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

The Division of Insurance is best positioned to assess Risk Based Capital and other solvency-oriented operating requirements for any organizations that assume risk within the ACC – even if partial risk is transferred and/or new forms of licensure (beyond existing insurance carrier, HMO and LSLPN standards) are developed for the purpose of risk sharing within the Colorado Medicaid program.

Stakeholder Engagement

38) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

The RCCO must create multiple channels of contact and to generate productive connections with clients, their families and advocates.

Generally speaking, this means "going to the people" rather than expecting them to "come to us".

In addition to the 'governance' functions that are generally emphasized for the purpose of engagement, there should be several opportunities for the *design* of new processes and programs – not the oversight and advocacy role they are expected to play.

Formal structures should be supplemented with a variety of informal convenings, feedback sessions, community prioritization and feedback processes.

39) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

There is a tremendous need for a "network development" initiative in this area that is commensurate with the focus on the "PCMP network" that HCPF has prioritized in the initial years of the ACC.

A focus on information sharing, comprehensive assessment and community response systems are the specific action areas the development of closer relationships.

40) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

Business, municipalities and local civic organizations are important partners that are (generally) less involved in the ACC than they could be at this point. A focus on closer connections with public officials (outside the usual health and human services space) is also a key opportunity,

41) How should the Department structure stakeholder engagement for the ACC as a whole?

There is already a significant amount of structure in place for oversight of regular program operations, or major program changes.

Marketing and communication functions could be coordinated more closely to improve awareness and understanding of the ACC. The Department and RCCOs could work together to design to and execute annual communication plans and with specific targets.

Network Adequacy and Creating a Comprehensive System of Care

42) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

Providers participating in the Colorado Medicaid program do not currently operate as a network – at least in the same manner that health plan, health system, IPA and multi-specialty groups do in other payer arrangements.

Acknowledging the qualitative difference between the list of Medicaid providers with billing rights, and the characteristics of a contractually established, organized payer-provider network, is the first step in making improvements.

Creation of a functional network (beyond the scope of PCMPs) will entail significant, ongoing, methodical effort on the part of the part of the Department, RCCOs and leaders within multiple provider-based organizations. The next area of focus should be on the creation of more efficient PCMP-specialty partnerships.

a. If no, what are the gaps?

There are well understood and documented gaps in access for Medicaid to specialty care services – in both rural and urban areas, in all specialties, procedural and non-procedural. With few exceptions, there is little contractual or financial leverage within the current Colorado Medicaid delivery system that can be utilized to improve access to specialty care services.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

The most likely path forward to improved access to specialty expertise in the near future is through initiatives that promote better knowledge sharing, communication, coordination and co-management arrangements between PCMPs and specialty care providers on a practice-by-practice, market-by-market basis. The "Project Echo", "Doc-to-Doc" and telemedicine initiatives currently under development within the ACC are all worthwhile, practical approaches to making things better.

43) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

We will defer to the providers and agencies themselves, in each category below, for a response on this topic. Our view is that all of these groups have a fundamentally important, unique role to play within the ACC. We particularly emphasize the importance of LPHA, counties and community entities in the success of this model – well outside the scope of traditional health care operations.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

44) How can RCCOs help to support clients and families in making and keeping appointments?

RCCOs can promote improved appointment keeping through a variety of mechanisms – from integrated scheduling arrangements with advanced practices, to targeted 'accompaniment' and transportation initiatives for specific cohorts of clients.

In the former case, some Region 1 community care teams (LPHA-based, in some instances) have been granted EHR access and scheduling access by advanced PCMPs. This is a very powerful process for expediting access to care when necessary and managing available primary care capacity effectively.

In the later case, community health workers funded by RCCO 1 and employed by the CMHCs transport clients to appointments, and provide close support before, during and after encounters to improve the client experience and maintain access to the PCMP. Again, this intervention has proven effective

45) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

Encourage, yes. Require, no.

46) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic (OR CMHC)	☒
On staff (salary) at RCCO	☒

Per Member Per Month Payment	☒

47) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

Oral health is a major driver in health risks and outcomes across the entire demographic spectrum of Medicaid eligibility.

Dental pain is a significant driver of avoidable emergency department utilization.

RCCOs are not in a particularly strong position to create new dental access points where none currently exist. FQHCs, RHCs and other safety-net clinics are in a much better position to create meaningful access to dental care.

The recent implementation of the adult dental benefit and a third party administrator may help to generate new Medicaid dental access points in traditional dental clinic settings.

Integration of oral health outreach, prioritization and follow-up activities should be a core focus area within RCCO care coordination programs. The Department could consider requesting the development of an RCCO plan for integration of oral health management activities, coordination and scheduling processes with the new dental administrator.

48) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well being of clients and families.

    a. What does cultural competence mean to you?

Cultural competence is primarily about *understonding thot there is* o *difference* between mainstream, middle class norms and priorities and those of other groups. These differences are manifest in numerous areas, from communication styles, to decision-making, household 'budgeting', schedule keeping, community values and countless other dynamics.

Additionally, regardless of cultural, language and ethnic differences – *poverty* necessitates a focus by individuals and families upon day-to-day *survivol*.

Cultural competence entails an understanding that 1) *the differences ore OK*, and 2) o *different opprooch to connecting ond communicoting* is necessary to make the ACC work. Success is seldom achieved by grafting mainstream norms and expectations onto other groups within the Medicaid program.

Evidence of an opportunity for greater cultural competence is evident throughout the delivery system on a day-to-day basis – in provider and clinician complaints, failed connections and interventions. E.g., --

-- "I can't believe that this patient is on *Medicoid* but still has money for a fancy iPhone."

Culturally competent response: Thank goodness we have a valid phone number where we can text and call the patient when necessary.

-- "They must be spending at least $500 per month *on their truck*."

Culturally competent response: Thank goodness the family has transportation. It is more likely that they will make their referrals and keep their appointments.

-- "She did not show up for her appointment, so we fired her. She needs to learn that there are consequences for her actions".

Culturally competent response: I wonder why this patient keeps missing her appointments. It would be good to understand her barriers. Maybe the RCCO or someone else can help get her in on time. Maybe there is a way that we can go to her – she really needs help. If we don't solve this problem now, it will cost the system much more money in the long run.

b. What RCCO requirements would ensure cultural competency?

Our own cultural norms and biases are often invisible to us – they are like the air that we breathe. Education and training programs can be very effective in enabling all individuals within an organization to understand differences and respond differently when confronted with cultural differences. *Bridges out of poverty* has been a very effective training curriculum for both front line staff and senior executives within our organization. Disability awareness training and client feedback sessions (facilitated by the Colorado Cross Disability Coalition) have also been very valuable to RCCO 1 and partnering organizations.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

Awareness and understanding are really the most important aptitudes. Language competencies, peer-based interventions, translation, transportation, smarter scheduling, community 'navigation' resources are all inputs to a culturally competent model, but of little use if deeper understanding about the nature of differences does not exist among system leaders and at the front lines in clinical and care management settings.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Of course, effective communication is more likely to occur when the communicator has a good working knowledge of a client's language and cultural context. Peers, promotoras, etc., are often the best means of reaching communities and creating broad based impact in this area. No RCCO should operate in this space without a solid strategy and commitment to developing partnerships and resources in this area.

Even when cultural gaps are bridged, individual *decision-making* and *behavior* remain the primary drivers of health disparities. Integration of behavioral resources, in both clinical and community settings, for a wider array of change objectives, is critical across the entire Medicaid population.

49) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

Yes – to the extent that they are actually be formed with the purpose of creating substantially better access to care.

This is more likely to happen if / where a capitalized, corporate health system commits a greater share of its specialty resources to serving a large volume of Medicaid clients – and is willing to take the financial hit or change in market position that is typically associated with doing so.

It is also more likely to happen if / where RCCOs can perform (or participate in) private payment functions to create leverage that generates better access to care – including multi-line and tiered network strategies that include incentives for serving the highest cost / most at risk populations.

Without these elements, a "preferred network" for Medicaid specialty care is an abstract concept, at best.

Limiting access to care in a system that self-limited due to a macro-economic shortage of supply makes little sense. Our time and focus will be better spent on other initiatives to expand access to specialty care.

50) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

This is a complex problem that requires a complex response. Focusing on the highest utilizers (where much of the excess utilization is concentrated) remains *a legitimate priority and focus area for the RCCOs*. Additionally, RCCOs and their partners are uniquely positioned to employ a wide variety of "non-health care" interventions that address the multi-faceted root of the problem.

Other changes, such as a "flat" (non-facility) based fee for Medicaid ED utilization, creating more powerful rewards for open scheduling and extend hours options in primary care, and (perhaps) the implementation of higher cost sharing for ED encounters are all worth considering. These changes are more likely to "treat the symptoms" of excessive ED utilization by the Medicaid population – not "cure" the underlying problem.

51) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

We think that the ACC is generally on the right path at this point – focused upon improvements that are achievable on a broad basis, not on abstract concepts or far flung changes that belie the macro-economic reality of the current Medicaid payment, regulatory and financing structure.

We can work on achievable changes now while advocating (and actively taking calculated risks) to develop more substantial improvements in the payment and delivery system model over time.

Practice Support

52) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☒
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☒	☐	☐	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☒	☐	☐	☐
Provide registries	☒	☐	☐	☐
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☒	☐	☐	☐
Supply behavioral health surveys	☒	☐	☐	☐
Supply other self-screening tools	☒	☐	☐	☐
Administer behavioral health surveys	☒	☐	☐	☐
Administer other self-screening tools	☒	☐	☐	☐
Prepare client action plans	☒	☐	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☒	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☒	☐
Provide visit agendas or templates	☐	☒	☐	☐
Provide standing pharmacy order templates	☐	☒	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☐
Provide directory of other resources	☒	☐	☐	☐
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others				

53) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

We have adopted and recommend tools developed by the ACP and NCQA. These tools primarily provide coherent guidelines – not specific, inflexible mandates – for more effective communication, coordination and co-management relationships between primary and specialty care providers.

54) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

RCCO resources vary in these areas, and robust practice transformation services may be beyond the scope that some organizations can provide on their own. However, RCCOs have a critical role to play in working collaboratively within a statewide framework for more consistent delivery of practice transformation supports in every community.

55) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

Recognition is best achieved through a qualitative, ongoing, in-person relationship. "Accreditation" and formal recognitions programs (e.g., NCQA) are useful, but not necessarily a definitive, categorical indicator of "medical home-ness".

Non-FFS payments (e.g., "PMPM" arrangements) are the most practical way to promote and expand this model. "Care management codes", etc., are less consistent with the population and outcomes focused basis of the model – and drive the system back toward "billable activity" and volume.

56) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

Encourage adoption of patient-centered registries (*without* regard to disease state)? Yes.

Require? No

57) Please share any other advice or suggestions about provider support in the ACC.

Providers can support themselves most effectively. The creation of 'natural' (not mandated, or forced) leadership and collaborative learning channels among practices statewide can be a very effective means of support. RCCOs (and other orgs) can facilitate these channels; mandating "attendance" and "credit" for participation is not recommended. Leaders lead, followers follow, and laggards lag – acknowledging this basic "distribution of transformative capacity" within the primary care base is the first step in developing resources and targeting efforts in a way that produces the greatest possible impact for the population.

Payment Structure and Quality Monitoring

58) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

The PMPM payments that are currently being made are consistent with the goals of the ACC, and the most practical way to operate given 1) the current fiscal and regulatory barriers to broader risk transfer within the program, and 2) the dearth of risk based capital among the small, not-for-profit organizations that have made commitments to advance the goals of the ACC.

In the short run, the Department should:

- Continue what you are currently doing. Make PMPM payments for critical inputs to the model – care coordination, data sharing, feedback analysis, the integration of community and behavioral health services. Afford RCCOs and their partners flexibility in determining how best to use the resources and close gaps wherever possible.

- Focus on creating a period of stability so that ACC partners and participants can solidify and capitalize upon the foundation for community integration that has been established since the first, incremental enrollments became effective 3 years ago.

- Balance focus on a basic set of quality metrics in key areas (e.g., well-child care) with progressively more sophisticated *structural* milestones of community integration among RCCOs and other ACC participants.

- Begin working intensively on waiver and/or any other federal authority necessary to address #1 above, as well as the need for an "alternative payment model" that does not regress to encounter volume.

59) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

We have developed some thoughts and insights in this area over the course of implementing our HB 12-1281 project. However, this question is not applicable to our organization. We defer to PCMP respondents.

60) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

"Infrastructure" is not necessarily a barrier to the adoption of smarter primary care payments. Enhanced, global payments for E&M and related services can be implemented for a wide range of PCMPs without substantial additional structure. RCCOs (in their current state) and the Department could reasonably accomplish this objective in the near term. The biggest barrier, in our view, is the encounter volume requirement that will persist absent an alternative payment waiver or similar reform.

61) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

Our organization is fully licensed. However, we encourage the Department explore additional forms of licensure or solvency certification to promote the broadest possible array of public-private risk sharing arrangements across community-based organizations within the ACC.

62) What role – if any – should the RCCOs play in the distribution of payments to providers?

RCCOs can perform an invaluable role in the distribution of payments to providers – even if they are not organizationally equipped with the operational platforms necessary for traditional payer functions.

The value of utilizing the RCCOs is inherent in their status as private organizations with direct accountability to the communities they serve. Unlike the government, RCCOs can:

- Contract very creatively and flexibly in a targeted manner;
- Tailor payment arrangements to meet specific needs and close individual gaps on an organization-by-organization basis;
- Make rapid cycle improvements and adjustments as circumstances change.

When government functions as a payer, the actions it takes are a matter of law and public policy, must be generally applicable on a broad basis, and are subject to substantial procurement constraints.

To the extent that RCCOs and/or private payers posses these characteristics and actively bridge gaps that the government can't fill, they should be actively encouraged to do so.

To the extent that RCCOS and/or private payers operate in a uniform, inflexible and bureaucratic manner, they add little value to the government payment process already exists. There is no need to layer private bureaucratic layers upon the underlying government bureaucracy.

We encourage the Department to understand and test differences among potential "payer partners" in this area.

63) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

Reforming payment, transferring risk and creating cost accountability are related, but distinct processes.

The greatest possible opportunity for improvement exists where are three elements can be brought together within a single agreement.

That said, it is possible to implement a variety of new payment models (and cost accountability structures) without a full transfer financial risk. Unless a large, new source of risk based capital materializes somewhere

within the program, full risk transfers are unlikely to occur on a broad basis within the state any time soon (even if waivers or other federal policy changes are adopted to facilitate a move away from FFS).

New payment models are likely to evolve in an accelerated manner to the extent that the RCCO (or similar entity) is utilized to promote them (per the response to Question 62) on a partial or non-risk basis. Striking a balance in this area, and cutting a path forward, is an essential next step in spurring broader payment reform across the Colorado Medicaid program – without compromising the community basis of the ACC (which is fundamental).

64) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

Guideline-based, process metrics are OK – whether they are generated with claims or clinical data. We think that the primary purpose of these measures is the development of basic quality improvement and data use competencies. Less is more with these measures (i.e., a list that is too long dilutes focus and can delay the development of core QI competencies in most settings and systems).

We have found, however, that there is much greater power in focusing on *structurol* measures of improvement. Milestones of transformation, operational care management metrics and reports that demonstrate the system is indeed accounting for people as it should are our primary focus at this point in time.

We are also excited to pilot sophisticated *outcomes oriented* measurement and payment initiatives, which capitalize upon extensive investments that we, partnering providers and community organizations have made over the years – such as the *Globol Outcomes Score ("GO Score")*. This pilot is comprehensive in scope, and includes RCCO enrollees along with all other patients served by advanced PCMPs. See: "NCQA, RMHP and the GO Score" – in the 2014 *Heolth Motters Report* published by the Colorado Business Group on Health www.cbghealth.org/pdfs/2014-HM_HealthPlans.pdf

A mix of structure and outcomes measures, in addition to contemporary process and "intermediate outcomes" measures that are available – is a critical balance that the Department must continue to strike in ACC efforts moving forward.

65) **Measuring Client experience**. Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	This is a useful tool, but continued "mixing and matching" clinical and health plan CAHPS questions is not recommended, because doing so eliminates the potential value of national benchmarks, and (in the case of the "PCMH" and "CG" elements) are not actionable without attribution to a specific provider group.

SF-12 Health Survey	☐	☒	The SF-12 survey can be administered but is not as actionable as other tools – at least without significantly greater integration.
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☒	☐	
Focus groups	☒	☐	Focus groups, Patient Family Advisory Committees, etc., are preferable to surveys as a means of generating actionable feedback on RCCO, PMCP and other ACC partner operations.
Other	Please type your response here.		

66) Knowing that, at this time, the Department only has claims data, how should population health be measured?

The administrative data is a powerful resource for population health management – don't discount it. It is useful primarily for population definitions, general targeting and aggregate feedback – both of which are critical in "population health measurement" functions.

The administrative data is far less useful for clinical decision-making and timely, front-line actions.

Understanding this difference is the key to making the right investments with administrative data, in tandem with other resources (e.g., real time alerts for timely response and follow-up, and clinical data aggregation that makes opportunities like the "GO Score" possible).

67) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

Publication of the "KPIs" is useful.

Progress on "structural" objectives (e.g., the number of assessments or follow-up actions completed) is also useful.

Maintaining open channels of communication about what is going on inside each RCCO and PCMP is essential, as well. In our experience, "KPIs" are important but seldom tell a complete story. We ourselves benefit greatly from close, in person contact with our providers, and deeper, qualitative understandings about "what is going on" in each site, over time. This process can be operationalized through the production of regular "narrative reports" (e.g., on a quarterly or semi-annual basis).

68) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	

1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-S0	☐
S1+	☐
None	☐

Less is more. See response to Question #64, above.

69) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☒
21-30%	☐
31-40%	☐
41-S0%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

We suggest a lower percentage not because we are opposed to "accountability for performance" in any way, but because per capita funding in the ACC is extremely limited, and should be directed at the development of long-term foundations and community systems

70) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Generally, yes. However, RCCO and PCMP development milestones vary somewhat. Provided the focus is upon the development of new systems, structure and process measures (e.g., the number and timeliness of "SCPs" completed within the new MME demo) can be very appropriately used as the basis of incentives.

Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Generally speaking, longitudinal improvement is a priority. However, national benchmarks (to the extent they exist) should be used to creative incentives for "maintenance" once performance has largely been optimized.

71) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

72) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☒

If you checked the "Other" box, please describe payment frequency below:

"Other" makes the most sense because measures of performance vary significantly from metric to metric, and require substantial differences in observation time. Generally speaking, more frequent payments (e.g., quarterly) are preferable to less frequent payments – but the frequency of payment should not be an end in itself. The validity and value of the measurement is of far greater importance.

73) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

The fixed costs present within RCCOs are common to any enterprise:

- Physical space, operating equipment, rent, utilities and other overhead expenses
- HR, personnel, legal, accounting, and related business process expenses.
- Compliance support for all federal, state, regulatory, contractual and operational reporting requirements (which are extensive)
- Enrollment, call center, IT services and security, laptop, telephone and similar operational expenses
- Audit, site visit and public reporting expenses support
- Leadership, governance and accountability related expenses.

74) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

This question is not directed toward our organization.

Health Information Technology (HIT)

75) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

76) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☒	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☒	☐
Practice assessment tools	☒	☐
Practice management tools (scheduling, billing)	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☒	☐
Shared decision-making tools	☒	☐
Telemedicine software	☐	☒
Other: Patient activation analysis and tools that support "coaching for activation",	☒	☐

Other:	☐	☐

77) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☒	☐	☐
Practice assessment tools	☐	☒	☐	☐	☐
Health risk assessment software	☐	☐	☒	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☒	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☒	☐	☐	☐
Patient education wellness tools	☐	☐	☒	☐	☐
Provider/case manager directory	☐	☐	☒	☐	☐
Shared decision-making tools	☐	☐	☐	☒	☐
Telemedicine	☐	☐	☐	☐	☒
Other:	☐	☐	☐	☐	☐

78) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Individual EHR vendor constraints, vendor timelines, upgrade, module and reporting costs are the largest barrier.

The creation of more efficient clinical processes for consistency in data capture, understanding of existing EHR and related application supports, and the relationship between internal business intelligence and quality improvement.

79) How can Health Information Technology support Behavioral Health Integration?

There are a variety of techniques, templates and charting processes that can be adopted by a practice (particularly when it 'owns' the BH resource directly) to document patient needs, track provider impact and

'productivity' (without reverting to FFS coding, develop and execute care plans and track referrals for more extended therapies and interventions.

The challenge of using HIT to support integration increases to the extent that two different "systems" must be maintained (e.g., encounter and regulatory reporting for the CMHC vs. the PCMP function), or when the organizational identity of an individual employee is split – thereby raising questions about rights, roles, confidentiality and consent that are not otherwise present when a single organization performs all functions.

80) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

The Department is well served to focus on the development of core infrastructure for data sharing and collection – not on individual applications and tools.

RCCOs and their partners can develop natural partnerships and application sharing arrangements much more nimbly on their own. The Department does not need to wade into the application space.

Even if the Department sponsors, controls through approval processes or mandates the use of specific applications or tools, all ACC partners will continue to develop and operate primarily within their own platforms.

We will all be better off if we accept that the creation of *networks and bridges* among multiple systems is the primary focus of our HIT strategy, not the creation of a "universal hub" or "single statewide platform".

81) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

See the response to # 80 above.

The key elements of an effective, community care management tool are:

- Designed with a robust, inter-organizational, rights and roles based architecture that can be configured at the lowest level possible within a community system without extensive technical support;
- A focus on the patient and his or her immediate needs – not the needs of individual provider groups or agencies, disease states, program categorizations or other common drivers in health IT platforms;
- A focus on the current status and activity around a patient, and clarity about "who is on first" for a specific social, behavioral, functional, family/caregiver or health care need.
- A "timeline" or "feed" function that contains information most pertinent to action – not the entire "clinical record" or history.
- The ability to integrate clinical data, administrative data, patient report data and alerts from other sources, as necessary and desirable – *without being dependent upon them or eloborote interfocing supports.*

In our experience to date, there are (surprisingly) few tools in the market that are designed with these features and use case concepts in mind. Most tools in this space are either payer or EHR centric, focus heavily on clinical functions, measurement reporting, guideline engines and "gaps in care" functions.

82) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

As with our response to the previous question, the needs for a shared population health management tool should be dependent upon the needs of particular communities, regions, or networked providers. A one size fits all, or a single shared resource, will not be optimal in many circumstances. Organizations participating in ACC activities must interact with organizations outside of the ACC. This interaction will vary dependent upon the needs and capabilities of the community, region, or network to which the organization belongs.

In the next iteration of the ACC, resources should be provided that facilitate shared population health management tools and align with the community, region, or network capabilities to which the organization belongs. The shared population health management tool efforts should not hinder or otherwise confound activities that are already occurring in communities, regions, or networks.

Basic criteria for population heath tools include the following:

- Identify patients with prevention, acute or chronic care needs, track gaps in care, evidence based care delivery
- Supports patient and family engagement tools
- Create feedback mechanisms for providers, practice teams and patients.
- Alerts can be provided to both patient and provider
- Care summaries are created and can be provided to the patient at time of visit and electronically
- Track multiple patient conditions or co-morbidities and presents pertinent patient data in summary flow sheet formats, can be queried in full detail
- Facilitate and document the production of a proactive care plan for a team or teams of collaborating clinicians
- Encompass the point of care support and reporting outputs needed to allow disparate providers to collaborate on the care of patients across multiple points of care and episodes of care or interventions
- Patient centered whole person oriented care form the basic foundations for population management
- Supply appropriate Community level quality metric reporting with such reporting able to address the needs of multiple stakeholders including but not limited to HIE's, payors, communities, geo-political areas, hospitals, IPA's and/or PHO's, individual practices, providers, and patients.
-

83) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

Simple, searchable, designed with "mobile-first" use cases in mind – with simple click-to-call (text or IM) design features that makes the directory as actionable for the client as possible.

The biggest challenge in deploying an effective directory is not the technology or user interface. It is the maintenance of accurate data, much of which is very detailed and can change without notice (e.g., panel status, operating hours, languages spoken, etc.).

84) How can the RCCOs support providers' access to actionable and timely clinical data?

RCCOs can do two things accelerate progress: 1) Create focus on specific measures and application use cases, in which the scope of critical data elements can be narrowed for productive purposes, and 2) promote and

sustain active feedback channels, which have the effect of improving data quality as well as the overall level of system performance.

85) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

86) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

RCCOs can support use case development, data collection, data mapping and matching functions, application deployment, training, data quality and exchange standards development.

87) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

Health information exchanges (HIE) like QHN can play a crucial role in an effective ACC. Because QHN has real time and historical access to data from all connected sources, use cases such as the following can be facilitated:

- Real time emergency department (ED/ER) admit notifications and inpatient admit/discharge notifications
- Supports care coordination/management/utilization and cost reduction programs
- Patient matching and patient subscription services can further enhance notifications regardless of provider relationship indicated at patient registration in hospital
- Notifications can be provisioned in a number of formats (Direct/secure email, sFTP PDF delivery, HL7, etc.) to fulfill individual provider technical or workflow needs
- Longitudinal access to the clinical data the HIE has collected from all sources over time
- Allows providers to see the complete picture of the patient regardless of if the patient switches providers or presents at a new provider
- Allows for HIPAA compliant access to data including advanced consent and privacy
- Can include behavioral health data with appropriate privacy and security safeguards
- Includes data from hospitals, laboratories, primary care, specialties, long term care, acute care, radiology and others
- Data provisioning for advanced value added applications and analytics
- The HIE can support data matching and normalization to facilitate population health, registry/wellness, risk stratification, patient engagement, care management and other HIT applications
- The longitudinal data the HIE stores can supplement the datasets required for advanced value added applications
- The HIE has relationships with the sources of data and works with those sources to obtain quality data for given use cases
- Results delivery to provider EHR systems
- HIEs standardize and consolidate the delivery of electronic clinical information to provider systems
- Efficient delivery of patient data to providers systems enhances providers access to data at the point of care
- Patient grouping and patient subscriptions

- Support providers creating patient groups or patient subscriptions that allow them to be notified in real time as data is received by the HIE
- Supports care coordination/management/utilization and cost reduction programs
- Patient groups/subscriptions creation can be manual or automated
- Community or regional provider "address books" and directories
- The HIE has relationships with providers within a community or a region and understands where data should go for a particular provider, and perhaps more importantly understands how that provider wants to receive data
- The HIE can facilitate senders and sources of data working with recipients of that data so that the data delivery works efficiently and is of maximum value to both

88) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Focus on broader based data sharing, data quality, data acquisition resources and interoperability standards. Avoid an "app centric" strategy. Private partners are in a better position to develop and test applications, which will come, go and change frequently over time. The biggest (unmet) need is the core infrastructure and processes for a statewide health information network.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 102

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Kandi Buckland
Location: Colorado Springs, El Paso, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Peak Vista Community Health Centers
Location: Colorado Springs, El Paso, Colorado
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Family Medicine, Pediatrics, OB/GYN
  ii. Area of practice: Primary Care
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Educational or research institution
☐ Another public or private program
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☒ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
PCMP, Delegated Care Management, Numerous RCCO Committees, Board of Directors for RCCO organization, Past RCCO Medical Director.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Medicaid provider of primary care for 40+ years.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

   a) The State's Medicaid expansion, enabling more underserved to have better access to health care.
   b) Funding for Care Management services enables patient access to this support.
   c) Integration of primary care and behavioral health.

2) What is not working well in the ACC Program?

   a) The lack of aligned financial incentives between physical and behavioral health care providers.
   b) The lack of timely financial data from the SDAC to identify and better address the health care of those patients who are high utilizers of inappropriate health care services. Difficult to obtain timely data, from any source, to effectively identify issues, needed changes in process, or patients to be served.
   c) The large number of RCCO members who remain unassigned to a PCMP.
   d) The current fragmentation of services that serve to make it difficult to achieve the Triple Aim.
   e) Lack of recognition of existing patient referral patterns in current RCCO regions.
   f) Differing regions for RCCO and BHO's makes it difficult to establish partnerships with one Behavioral Health practice.
   g) Differing goals, policies/procedures between RCCO's and BHO's make it difficult to coordinate care and utilize best practices for the patient.
   h) Lack of focus/funding on prevention especially for patients who are in a 'rising risk' category.
   i) Incentive methodology requires the entire RCCO to reach KPI's. PCMP's who are meet the KPI's for their population are not able to receive the financial incentive.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

   a) Their recognized need to work collaboratively with physical health providers in primary care practices.

4) What is not working well in the BHO system?

   a) Their perception that they need to be in the financial driver's seat due to the State's SIM initiative
   b) The lack of aligned incentives between physical and mental health providers
   c) Their lack of an adequate number of prescribers to provide timely services to their clients
   d) The lack of congruence of RCCO and BHO regions
   e) The State's continued requirement for use of the CCAR, a tool that is not an evidence-based, nor a patient directed validated outcome measure that is overly cumbersome and time consuming to complete
   f) The fact that the State allows the flow of State Medicaid funds to be diverted from patient care services to private corporation's shareholders, i.e., allowing for-profit entities to be paid by Medicaid dollars
   g) Inability to utilize health and wellness codes.
   h) Fragmented care coordination services.

5) What is working well with RCCO and BHO collaboration right now?

a) The fact that we are finding ways to work together.
b) Potential future incentives (SIM) that encourage collaboration and partnership.
c) Future payment reform is an incentives to increase collaboration.

6) What is not working well with RCCO and BHO collaboration right now?

a) The lack of aligned incentives between physical and mental health providers.
b) Lack of joint goals and processes.
c) Differing regulations on who is eligible for services and payment methodology.
d) Differing requirements for coding.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

a) The State should abandon use of the CCAR and adopt an evidence-based outcome measuring tool, such as the SAMHSA approved Partners for Change Outcome Management System (PCOMS), or at a minimum, the Outcome Rating Scale component of PCOMS.
b) The State should align the BHO and RCCO regions in such a manner so as to better recognize existing practice referral patterns. Require the same functions as though they are one organization.
c) The state should require timelier reporting of billing data by the SDAC.
d) Open the health and wellness codes.
e) Consider focusing care coordination for both behavioral health and physical health through primary care as this is where the client is most frequently seen. Assure a smooth transition process from integrated behavioral/primary health to mental health services to serve complex mental health issues.
f) Payment reform to allow for integration or at a minimum, bridge funding assisting local providers to move in this direction.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	BHO and RCCO financing should be better aligned. Assure ongoing funding stream for chronically mentally ill.
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☒	☐	Need to open Health and Wellness codes. Review all codes from an integrated perspective
Different behavioral / physical health reimbursement	☒	☐	Need to have one system of payment, i.e. all (BH/Medical) capitated, fee for services, or a blend of both but not different payment systems.
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	Need consistency between agencies. Review/revise based on an integrated model.
PCMP financing structure	☒	☐	Specialty care payment is inadequate which limits ability to refer clients to specialty services.
Per-member per-month amount	☒	☐	Needs to cover costs of required services.
Physical space constraints	☒	☐	Need to be able to reconfigure physical space in order to accommodate an integrated model with BH and other care team members. This will require assistance with construction costs.
Privacy Laws (HIPAA, 42 CFR)	☐	☒	
Professional / cultural divisions	☒	☐	Language/terms used by the Behavioral/mental health system differ from physical health system. Creates confusion, misunderstanding, and errors. Need to be able to align this for an integrated model. For instance, a 'Care Plan' for physical health system is an outline of what is needed for the client. It is easy to create without numerous requirements on content. 'Care Plan' for Behavioral/mental health system contains numerous requirements and extremely time intensive. Having a

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

			similar Care Plan will ensure coordinate care. Differences in financing create differences in the number of clients to be served. Primary care (FFS) is able to see as many patients as possible where BH (capitated) can serve only (x number) of patients or they exceed the capitated amount. Historic differences in encounter time (scheduling patients) create barriers. Primary care historically sees one patient every 15-20 minutes. Behavioral Health schedules one patient per hour. Thus in an integrated model the ability to work within a fast paced model is difficult. Need to change expectations as to what is provided in an integrated model as opposed to mental health model.
RCCO or BHO contracts	☒	☐	Need to be reflective of an integrated model with similar or same expectations.
Staff capacity	☒	☐	Effective care coordination takes time and requires adequate staffing. This will save money in the future but is costly in the current environment. There isn't adequate numbers of mental health staff who are able to prescribe medications and it takes months for a client to reach someone who can prescribe meds.
State/Federal rules or reporting requirements	☒	☐	Need to eliminate the CCAR requirement and utilize PCOMS tools. Align physical health and behavioral health reporting requirements.
Technical resources / data sharing	☒	☐	Issues with multiple IT systems; CORHIO doesn't have data warehouse capacity which requires additional costs for purchasing other systems. There is a competitive feeling that whoever holds the data has control which is not effective to integrated care.
Training	☒	☐	Most professional staff has not been trained in an integrated model thus there are numerous ideas on what is/isn't included in such a model. Consistent definitions and services need to be developed with specific training provided.
Others	Attribution process is a huge barrier. In our RCCO there is a 30% unattributed rate which is unacceptable. The process for attribution is flawed, cumbersome, and needs to be user friendly. Frequent attribution changes from provider to provider further fragments care and increases confusion for PMCP's and clients.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

Clinics should meet generally recognized standards such as those in place for AAAHC, JCAHO, and NCQA.

A system which provides a holistic approach to healthcare in which they are able to identify and treat all aspects of a person's health, to include but not limited to, physical, behavioral, oral, financial. The patient is truly the "center" of their healthcare and the patient dictates their needs with the support of the multidisciplinary teams. Shared information is seamless between the providers, patients, and care givers.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

There needs to be a better understanding of what is meant by "integrated care". As previous stated, there are multiple definitions and practices but how does Colorado define this? Include clarity around what types of services are best provided in a primary care office as opposed to a warm hand off to mental health for complex cases. There is not a smooth transition of care process at this point which further delays care, creates confusion, and promotes fragmentation.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

b. How should RCCOs prioritize who receives care coordination first?

RCCO's need to work closely with PCMP's to identify patients in need of care coordination. This should be done through review/analysis of population data, cost data, patient engagement, health status, and care. The RCCO should not make this determination independently and dictate/require care coordination for specific patients or diagnosis.

We need to remember that this is a new direction and process in Colorado so locking care coordination into specific areas will kill creativity and innovative approaches to care coordination. It is premature to mandate this.

We cannot forgot the importance of keep care coordination patient centered. Giving RCCO's the authority to determine what the patient needs and when is in direct opposition of assuring services are patient centered. While many talk about patient centered care, few actually provide services in this manner. We need more focus on what this means and how to work when care is truly patient centered.

RCCO's should spend their efforts in reviewing data and providing timely information to PCMP. PCMP should determine who needs care coordination and when.

c. How should RCCOs identify clients and families who need care coordination?

As HCPF stated in earlier sections of this document: *"Toking steps towords integration ar better coordinotion of physicol ond behoviorol heolth care for Medicaid clients is o primory gool of the next RFP. Behoviorol heolth care refers to oll services to treot heolth conditions thot primorily present os olterotions in thinking, mood or behavior ond chonges in emotional (mood), psychologicol (thinking), or sociol well-being (behavior) and conditians reloted to addictions."* Medical diagnoses and rising risk along with the clients ability to adapt and be engaged in their health also dictates who may need care coordination.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

   Through standardized reporting of the number of clients receiving care coordination. Suggest support for care coordination and population based software such as Crimson.

12) What services should be coordinated and are there services that should not be a part of care coordination?

We need to work further 'upstream' to identify clients at risk or are demonstrating rising risk and intervene with care coordination at that point. Waiting and only working with the highest utilizers is very shortsighted and will not have the long term, cost saving results. Encouraging RCCO's, BHO's, and PCMP's to work further upstream and incentivizing work in this area will move us towards the triple aim much faster with long term savings.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

   It seems that everyone is providing care coordination which has created further fragmentation, confusion, and to some level, distrust in the system. Clients receive calls from "care coordination" staff in hospitals, payers, PCP's, specialist, Behavioral Health, Fire Departments, Home Health and other agencies. Information is kept within the specific system, rarely shared as it is extremely difficult to share (time, processes) and thus we see increase fragmentation, duplication of services and solicitation of information from the client, and as a result, confusion/distrust.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

   Not sure that it is different. Each as a special niche based on the type of organization but we still miss the fundamental objective of care coordination is the overall responsibility to help the patient with multiple providers, services, and social issues. The current system doesn't help the client

coordinate their care; it simply coordinates the needs of that specific system's needs with the patient. Many times RCCO are increasing this confusion by the multiple "pilot" projects to expand care coordination versus working with the PCMP to truly coordinate the client's care.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	
Health literacy	☐	☐	☐	
Housing	☐	☐	☐	

Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	
Transportation	☐	☐	☐	
Other	This chart is difficult to complete as clarification is needed to identify if we believe RCCO's should work at the systems level with these agencies or on specific patient centered issues with these agencies. We believe RCCO's should work at a systems level, along with public health, to assure the systems are in place to assist all clients in need, not just those with a specific fund sources. RCCO's should not work on individual client issues as this is the role for the PCMP's care coordination staff based on the needs of the client.			

16) **Requirements about who should be doing care coordination**. Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	**Coordinate care?** Yes	No	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
\Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	

Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Colorado should not specific who should/shouldn't be a part of care coordination as it will be very client specific based on the clients health, psychosocial, and environmental needs as well as who the client relates the best with and who they trust.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	

Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
It is likely that clients from all the above populations may need care coordination at any given time. Utilizing appropriate standards of care for all the populations is required. By using the standards of care it will become apparent what adjustments would be needed to meet the unique needs of the client as a result. In addition, it's essential that a robust system of specialty services be available to address unique patient needs like HIV, cardiology, etc and be coordinated to the PCP. This meets medical home model standards.			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

This could be a slippery slope as it's important to not confuse/conflict with the DHS system in Colorado. All children receive care from a PCMP and thus would receive care coordination services as warranted for their condition/social/emotional issues.

19) How should care coordination be evaluated? How should its outcomes be measured?

Colorado should agree to specific outcome measurements (Healthy People, NCQA, as examples). RCCO's should work with PCMP to identified any locally unique or specific measurements that should be measured.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

Not at this time. It would create more complexity in a new system and there is not have enough experience with this to adequately assess the differences.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

There should not be a client ratio requirement for care coordination. This needs to be determined by the PCMP providing the care based on the client's needs and level of care coordination required.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

Should be evaluated based on movement towards the Triple Aim.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Consistent data reporting from RCCO's to PCMP's and from PCMP's to the RCCO would be helpful. It is extremely difficult to determine utilization and services in the current model.

RCCO offices should be in the region they serve.

RCCO contractors should be non-profit or capped at a certain percentage for shareholders.

Care Coordination should always be delegated unless a practice is unable to perform this service.

Reporting should be consistent to the RCCO's and from RCCO's to PMCPs.

RCCO should be responsible for accurate and timely attribution of patients.

RCCO incentives should reward individual movement on KPI's as well as RCCO-wide incentives.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes – RCCO and BHO region maps should be the same. Change BHO regions to RCCO regions.

28) Should the BHO region maps change? Why or why not? If so, how? – see above 27.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

One RCCO per region would be preferred assuming the region is based on custom referral and service practices.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

RCCO's should have an active, performance based role in assure patients within their region are attributed. However, the entire attribution system needs to be review and revised to assure that the RCCO's have access to appropriate timely data and the attribution process is user friendly.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population? - NO

a. If no, what are the gaps? Many do not accept Medicaid patients or limit their practice. While this may be needed from a practice perspective, there needs to be incentives to those practices who serve mostly Medicaid patients (FQHC's) and there needs to be incentives/payment to encourage adequate specialty care access.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

If PCMP's are responsible for care coordination then adding a requirement to RCCO's for navigators or community health workers does not appear needed. While both offer support, this can be done through the PCMP system based on need not a mandate.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	Utilized may many agencies as the tool to measure client satisfaction and experience.
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	The State should abandon use of the CCAR and adopt an evidence-based outcome measuring tool, such as the SAMHSA approved evidence-based practice Partners for Change Outcome Management System (PCOMS), or at a minimum, the Outcome Rating Scale component of PCOMS. This tool measures a patient's perception of their own distress in four life domains, individual, interpersonal/family, social, and overall. Note that this tool is atheoretical and applicable to any and all diagnostic categories, and therefore well suited to address "all services to treat health conditions that primarily present as alterations in thinking, mood or behavior and changes in emotional (mood), psychological (thinking), or social well-being (behavior) and conditions related to addictions."		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	

1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☒	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the 5DAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☐	☒	☐
Health risk assessment software	☐	☐	☐	☐	☒
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☒
Patient education wellness tools	☐	☐	☐	☐	☒
Provider/case manager directory	☐	☐	☒	☐	☐
Shared decision-making tools	☐	☐	☐	☒	☐
Telemedicine	☐	☐	☒	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Cost; issues with software integration

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 103

Accepted by: KJDW

Notes: Formatting standardized

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

ACC Request for Information

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Stephen R. Thompson, LCSW
Location: Fort Collins, Larimer County, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: University of Colorado Health (aka Poudre Valley Health System): Community Health Improvement department, AND the Northern Larimer County Medicaid Accountable Care Oversight Committee
Location: Fort Collins; Larimer County, CO

☐ Please check if you are answering on behalf of this entity – Yes on behalf of the Oversight Committee; no as an official answer from UCHealth.

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☒ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: care coordination
  ii. Area of practice: community health
☒ Provider advocate (e.g. medical society)
☒ Other (please describe): Program Mgr. for the Fort Collins 'Medicaid ACC' team: provide direct care coordination services to ACC members in this area

Are you currently involved in the ACC program?

☒ Yes

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☒ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:

The Fort Collins' 'MACC' team has contracted with the RCCO in Region 1 (Rocky Mtn Health Plans) to provide moderately-intensive to intensive care coordination services to ACC members with complex needs or high costs. MACC works closely with RMHP to serve the Region 1 population, and delineates clientele based on geographic location and clinical and psych-social complexity. The MACC team is an interdisciplinary group comprised of clinical social workers, behaviorists, RN's, an NP, and several 'generalist' case managers.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

As an 'extension' of RCCO Region 1, MACC is very familiar with HCPF and CO Medicaid.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely

Since early 2012, MACC has made significant impact with very complex ACC members who have participated in our program, including adults, children, and families, which include improved health outcomes and reduced Medicaid costs (esp. ED utilization). We are also integrated into the three main family practice clinics, which are considered medical homes, in Fort Collins.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

In the Fort Collins community, local leadership has been able to work with the RCCO for Region 1 (Rocky Mtn. Health Plans) to develop a model to best meet the needs of the local ACC Medicaid population in need of care coordination. RMHP has been a wonderful partner in the evolution of our community's 'MACC' (Medicaid Accountable Care Collaborative) program, which is housed in the Community Health Improvement dept. of UCHealth / Poudre Valley Health System. Key stakeholders in our community have been very vested in this program since its inception in 2011, including: Touchstone Health Partners (local mental health provider), the Health District, UCHealth/PVHS, and three major clinics which are considered PCMH's locally (Family Medicine Center, Salud Family Clinic, and Associates in Family Medicine). Each entity has leadership representation on MACC's 'Oversight Committee', which has helped to develop strategies for targeting and prioritizing, client outreach and engagement, and ongoing care coordination services to ACC clients who participate in the MACC program.

The MACC team uses a combination of focused, internal targeting of ACC members who are considered 'super-users' of hospital services (including the local Emerg. Dept's), while also receiving external referrals from local providers and behavioral health staff at our partnering clinics. RMHP is able to provide sophisticated, organized Medicaid claims data on a monthly basis to the MACC team for use in targeting ACC members with extreme use of the ED, significantly high costs, multiple chronic medical / mental health conditions, and/or high potentially avoidable costs. MACC has also done an extensive amount of community outreach to foster relationships with agencies which there is a lot of overlap in clientele, such as: Foothills Gateway (community-centered board), Touchstone staff (mental health); clinic staff, Adult and Child Protection dept's (Larimer County entities), Larimer County Dept. of Health, and other local agencies (such as housing, dental, workforce center, etc.). Since the MACC team is part of UCHealth, the staff (now up to 10.3 FTE) is fully integrated with UCHealth, including Poudre Valley Hospital in Fort Collins and Medical Center of the Rockies in Loveland. We are able to monitor these hospital's admissions for any MACC client who presents to the ED or is admitted to the hospital to provide support for such transitions of care.

Given the nature of this interdisciplinary team, its integration with key community stakeholders and the local hospital / healthcare system, and the level of investment with local clinic leadership, and the excellent relationship that have been developed with the RCCO RMHP, the strong recommendation of our local MACC Oversight Committee is for the next iteration of the ACC to recognize that the relationship between a local team such as MACC Fort Collins and the RCCO is of high importance, and this should be preserved at all costs so that all of the work and development of a highly-functioning local model of service delivery is not lost. The MACC program has a lot of positive momentum at this point, and has a very talented team that is serving some of the most challenging, clinically complex clients in this community with patient centered, high-quality services.

To date, the local MACC team has served nearly 650 ACC clients (adults, children, families), usually with highly complex needs. The team uses a program model with dynamic caseloads, and clients are able to move through the program at varying timelines depending on their specific needs. For each client that is 'opened' in the MACC program, a comprehensive intake assessment is completed, and a plan of care is developed in conjunction with the client/family, the primary care provider, and incorporates input gleaned by the clinician or care coordinator on the MACC team based on intake information.

MACC did an initial analysis in early summer 2014 of reduction of ED utilization for some of the program's highest users of the ED (i.e., we see many clients with >30 or 40 ED visits in a 12-month period). Initial pre/post comparison showed a reduction of approximately 24% for a sample of about 80 high-utilizer clients. In addition to such quantitative outcomes, the MACC team has impacted countless numbers of local high-needs, high-risk, or high-complexity clients or families through its services to local ACC members in the Fort Collins area.

2) What is not working well in the ACC Program?

We have noticed some issues with SDAC data recently, where Medicaid claims have not been captured on a large number of ACC members since ~May of 2014. The MACC team relies on such information for its internal targeting efforts, and we believe that RMHP is working with HCPF and the SDAC to address the flow of data.

We would also mention that we have had countless struggles with the transportation vendor, formerly First Transit, now Total Transit as of Nov. 2014. Our clients rely on this service, and it can be very distressing for them when a scheduled ride does not show up, the vendor will not approve reimbursement, or the vendor states they did not receive paperwork or authorization after we have sent it to the appropriate contact at the vendor.

Finally, we have noticed many issues with attributions, including incorrect attributions. We have worked with HealthCO to try to update these attribution errors as we catch them, but are not have great success rates thus far with getting attributions corrected.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

At the local level, MACC is fully integrated with the local mental health provider, which is Touchstone Health Partners in Fort Collins. The MACC team now has 4.0 FTE contracted staff embedded in the team, who are Touchstone employees. This gives the team capacity to provide direct mental health services (such as intakes, facilitation to engaging in tx, or direct provision or BH tx in extenuating circumstances) for clients who have or perceive barriers to accessing MH tx via a traditional or agency route. MACC does not have a lot of interface with the BHO on a regional level, but interface nearly daily with the local MH agency (THP) that provides direct services in this community.

4) What is not working well in the BHO system?

No input here – at the local level, we have a very established and close working relationship with Touchstone Health Partners (formerly 'Larimer Center for Mental Health'). Of note, we have estimated that a majority of our program clientele (upwards of 70-80%, even) do have a mental health component to their care (includes non 'major-mental illness' dx's, as well as severe and persistent MMI dx's).

5) What is working well with RCCO and BHO collaboration right now?

Within our local model, Touchstone Health Partners has been a key stakeholder since the MACC team's inception in late 2011. Touchstone has leadership personnel participating in the MACC program's monthly steering committee meetings, and as noted above, now has 4.0 FTE staff (including two LCSW Behavioral Health Specialists) embedded in the MACC team.

6) What is not working well with RCCO and BHO collaboration right now?

Not aware of any problems.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Further development of services and more flexible funding that supports local agencies and programs designed to serve individuals with severe and persistent mental illness, substance use disorders, and/or co-occurring disorders (SPMI and substance abuse), would be of immense value locally.

It is essential that Colorado finds ways to reduce the funding barriers and information-gathering and sharing barriers to locating mental health services within primary care.

Full parity for a full continuum of evidence-based substance use disorders (including intensive outpatient and residential treatment) may be the most important tool Colorado could develop to interrupt the cycle of very poor outcomes and high costs for those with the most complex needs. We consistently find that the majority of high utilizers of care have significant behavioral health issues, and there is only so much that care coordination can do to impact those issues.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	The structure would likely work better if it were true capitation – with full flexibility, rather than a FFS/capitation hybrid that only allows funding for certain services.
Community Behavioral Health Services Rule	☐	☐	Unable to comment
Covered diagnoses list	☐	☐	Unable to comment
Different behavioral / physical health reimbursement	☐	☐	Unable to comment
Institutions for Mental Diseases exclusion	☐	☐	Unable to comment
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	Need to be streamlined considerably
PCMP financing structure	☐	☐	Unable to comment
Per-member per-month amount	☐	☐	Unable to comment
Physical space constraints	☐	☐	Unable to comment
Privacy Laws (HIPAA, 42 CFR)	☒	☐	May be time to change 42CFR in order to achieve the objectives of integrated care. Also, organizations need consistent guidance in understanding the possibilities for their organizations – a lot of resources are being wasted by the lack of clarity.
Professional / cultural divisions	☐	☐	Unable to comment
RCCO or BHO contracts	☐	☐	Unable to comment
Staff capacity	☒	☐	Behavioral health funding in CO does not allow for a full continuum of evidence-based practices, and focuses most resources on SPMI.

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

State/Federal rules or reporting requirements	☐	☐	Unable to comment
Technical resources / data sharing	☐	☐	Unable to comment
Training	☐	☐	Unable to comment
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

A clinic that truly understands and practices a model of 'primary care medical home' (or primary care medical neighborhood), employs a patient-centered approach, and is able to effectively collaborate and partner with whatever entity or resource may address behavioral health care, should be recognized as providing whole-family care. Additionally, clinics and/or providers who are willing to partner with resources that operate outside of clinic walls (such as the MACC team) may have better success and outcomes in addressing the multiplicity of determinants that may influence overall wellness.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Ongoing education to medical providers, and identifying local resources that can facilitate fostering relationships, information sharing, and open communication between medical and behavioral providers, would be of value. Oftentimes, I have seen in my experience that medical and mental health services are somewhat separate and distinct, and medical providers perceive some challenges at times in getting information from mental health providers due to stringencies around information sharing of mental health or substance abuse related interventions.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination? Locally, the MACC team generally defines care coordination as a targeted, focused, client-centered approach that provides overall coordination of health and mental health care directly to the client, while also considering other community resources that may be useful of beneficial to the client/family. Client needs and problems are prioritized by urgency with the help of a care coordinator, incorporating input from the client and provider directly. Using a standardized intake assessment for the MACC program, staff are able to develop a care plan that sets out realistic goals which are prioritized by clinical, psych, or social urgency, and this becomes the 'body of work' that is implemented with an active program client. The Care Plan is revisited periodically to measure outcomes, successes, ongoing barriers/problems, and also to incorporate new goals as situations change.

b. How should RCCOs prioritize who receives care coordination first? This is a great question. Not all high-needs clients will reflect high utilization or high cost data, as many social needs can be very significant barriers for a client or family to have their health/mental health care needs met adequately. MACC tends to use a comprehensive 'bio-psych-social' model when sizing up who needs services the most. It can be limiting to only consider one or two data points (such as ED utilization, or cost) – although that approach certainly has value in targeting a select sub-set of the population who likely is incurring a majority of cost. Our suggestion is that programs across the state develop a baseline 'client mix' when prioritizing who should receive services. For example, our local MACC's target client mix has been developed to be roughly ~50% super-users of the system (for example, people who have had 3 or more ED visits and $3,000 or more in PPE (potentially preventable events) or10 or more ED visits in a one-year period). For the remaining 50%, we anticipate that 1/3 of them will be people from the ACC MMP program, 1/3 will be clients with chronic conditions for which evidence exists that intervention is effective (for example, asthma, post-acute stroke patients, complex frail elderly living independently and high risk/high cost medication management), and the remaining 1/3 we reserve to be responsive to providers who are asking for help with their most challenging or difficult patients. Please note these groups are never completely mutually exclusive, and caseloads must remain dynamic as goals are met so clients can discharge from the program and new clients can be enrolled.

c. How should RCCOs identify clients and families who need care coordination?

In addition to the criteria used above, the MACC team and RMHP have implemented a tiered 'level of acuity' system to create very general categories / levels of needs. For example, we have tiers 1 – 5, where the lower the tier, the less complex the client's health/mental health care needs are. The MACC team is designed to get

involved locally with the higher-complexity subset of the ACC population – high level 3, level 4, and level 5. RMHP, our RCCO, generally provides any coordination needed at the lower levels.

As a point of reference for example, a 'level 4' patient in this tiered model would typically be a person who has multiple chronic conditions that are not well controlled, may have a concurrent underlying mental health dx that impacts that pt's ability to manage the condition(s) (i.e. diabetes, HTN, heart failure, etc), has social determinants that impact their healthcare (i.e. transportation issues, or cannot afford co-pays), has not historically done well with medical compliance, follow-through, or maintained consistent involvement with their PCMH, and may use the ED much more frequently than the rest of the ACC population.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider? Our suggestion would be to develop a basic reporting tool that can track a few key elements of care coordination. The MACC team tracks and reports on program clients regularly (i.e.: how many ACC clients are currently 'open' and active in MACC; outbound referrals made; how many clients have been targetedor have been offered services but have refused), and communicates closely with providers and PCMH's to collaborate on care plans.

12) What services should be coordinated and are there services that should not be a part of care coordination? Services of primary importance are: facilitation of a consistent connection to a PCMH; ensuring referrals to specialists are completed when indicated; screening for mental health needs and connection to appropriate resources when indicated; screening for other general community resources (such as housing, dental, in-home 'unskilled' services, transportation); chronic disease management and education; medications support and reconciliation; hands-on facilitation and support through any transition of care (when admitted, or after presenting to an ED); and direct discussions with clients around inappropriate use of the emergency dept. for 'super-users' of the system, to education on other options such as acute visits at clinics, urgent care, 24/7 Nurse hotline, etc.

Services that may be outside the realm of medical care coordination sometimes include: non-medical related goals or issues that a client wants to pursue (i.e. 'I'd like to learn how to fly-fish', or 'I signed on for this car loan but now I can't afford the payments'). It is important to note that such goals should not be diminished or ignored in the scope of CC work – but rather our role would be to identify other resources that may be useful in helping the client to attain such goals or receive help with issues that fall outside the scope of a medical care coordination model.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs? MACC process for screening new referrals and client needs always includes a comprehensive chart review to understand all available clinical information and hx. A client's medical and mental health diagnoses and related treatment should be understood. Additionally, understanding who or which agencies may already be involved with the client is important – MACC is not trying to reinvent the wheel for all needs, but rather collaborates with other resources to meet a client's

comprehensive needs. Social needs or barriers should also be understood. System utilization should be considered; medications should be reviewed, and assessment of a client's compliance and baseline understanding of their med's should be conducted. A bio-psych-social assessment is imperative for developing a plan to meet the client's healthcare needs, and incorporating input from the client and provider(s) helps to ensure a well-rounded care plan is implemented.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today? MACC makes every effort to understand which services or organizations are involved with the client (such as: single-entry points; mental health; home care; community centered boards;) and communicates and collaborates with these resources to deliver efficient comprehensive services that are not duplicated. Working across systems, and helping clients navigate these large, cumbersome systems, is essential. Identifying gaps in services is part of our assessment process; these gaps are addressed through community resource brokerage and hands-on facilitation of outbound referrals.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different? Clients may receive varying levels of CC services from non-RCCO entities. We have found that oftentimes the level of intensity of such services is lesser than what our team is able to provide; however, fostering a working relationship with outside entities is necessary and part of our process. The needs of the client must be weighed against what is already in place, and an assessment of how well current services are meeting client needs is conducted. Based on this information, MACC can proceed with efforts to augment or complement services as needed.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships? Approaching other agencies / services with a good-faith effort to understand the culture of that system, and communicating a respect for what is already being done, is a good start. Any client receiving CC through the RCCO or a local RCCO-contracted care team such as MACC in Fort Collins should be assessed to determine who is already involved, at what level of intensity is the service being provided at, and is the current matrix of services adequate for the client's needs.

d. What are the gaps in care coordination across the continuum of care? It is going to be a challeng to provide the level of care coordination needed for all patients who need moderately intensive to intensive care coordination, particularly with the addition of the ACC MMP program. Regarding other gaps in services that make care coordination difficult: earlier in MACC's work, dental needs for adults was very challenging – although this has improved with recent Medicaid expansion to provide dental coverage for adults. We still struggle with transportation needs, and the prior (and so far, current) HCPF NEMT vendors were not considered entirely reliable. Finally, some specialists are hard to locate and get appointments for, and sometimes the only option for such specialists

(i.e.: Neuro-Psychological evaluations; pediatric Hematology, etc.) are only available in Denver, well-outside the Fort Collins community. We need to develop an understanding from the NEMT vendor that these are appropriate consultations for clients, and the resource is not available locally – therefore we should not be running into significant challenges when attempting to schedule rides for such appointments.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☒	Resources exist locally – RCCO does not have to re-invent programs/resources, but rather should foster working relationships with agencies such as local DHS, adult/child protection; child advocacy centers, etc.
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	Prescription assistance programs exist in our community, and I am sure in many others. Also, within our local model, we were able to approve a discretionary 'client assistance fund' which has been invaluable for us to access for such client needs as Rx copays, clinic copays, urgent transportation needs, etc.
Daycare / childcare	☐	☐	☒	This is often a social need that can impact an adult's ability to access their own healthcare needs; efforts to identify resources / information by local community could be undertaken – RCCO could act as an informational resource by region
Economic stability & employment	☐	☐	☒	Same as above
Education	☐	☐	☒	Same as above
Environment	☐	☐	☒	Same as above
Food access / nutrition	☐	☐	☒	This is a basic need; many communities have food banks, but implementation of diet/exercise education as they may impact a chronic condition (diabetes; obesity) could be valuable and should be incorporated into a client's care plan when appropriate

Health literacy	☒	☐	☒	RCCO's and local care teams should absolutely be working to educate the client on chronic disease mgmt. and medications compliance
Housing	☐	☐	☒	Again, a basic need – but many communities have their own resources. Housing is a very difficult resource to access on a short-timeline; many of our 'super-users' of the ED are homeless
Language or translation services	☒	☐	☒	RCCO's and care teams should be able to access interpretation services as needed, so a non-English speaking client or family does not go without services solely due to a language barrier
Literacy	☐	☐	☒	RCCO may be able to provide community-specific information on local resources that address literacy; coordination with local resources would be useful for the client
Transportation	☒	☐	☒	Yes please – anything the State or the RCCO can do to improve the HCPF-contracted NEMT vendor's services would be greatly appreciated. This resource is common to many of our clients, and tends to be unreliable and difficult/time-consuming to access
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	Chronic disease education and management; medications education and management; collaboration with PCP's to address medications concerns or duplicative med's;
Certified Addiction Councilors	☒	☐	Addictions is a common theme across MACC clientele; employing clinicians who can meet clients where they are at, and encourage movement along a change continuum, are very valuable resources on our care team
Certified Nurse Midwives	☒	☐	MACC has not had this discipline as part of the care team previously, however it could be useful for a small % of the population. We use RN's that do home visits for newborn Medicaid infants to provide lactation support, screen for issues (jaundice, weight gain), and ensure f/u for WCC's with PCP's
Community Health Workers	☒	☐	Generalist 'care coordinators' or 'case managers' can work with a variety of clients who have primarily social or care coordination needs
Generalists (BA/BS/MA/MS)	☒	☐	Same as above
Health Coaches	☒	☐	Generalist roles
Licensed Clinical Social Workers	☒	☐	MACC has three LCSW's on staff (including myself as the Manager of CC Programs). I feel that this level of clinical expertise, a knowledge of working across systems, and an ability to meet clients where they are at when starting to work with them, is essential.
Licensed Marriage and Family Therapist	☒	☐	LCSW's can provide this type of intervention; this need has not come up for us very much, at least to a level that could not be managed by an LCSW
Licensed Mental Health Counselors	☒	☐	Focus on SPMI and clients with significant substance abuse challenges
Licensed Professional Counselor	☒	☐	Same as above
Masters of Public Health	☒	☐	Could be useful when looking at population health mgmt

Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	May not need to be a direct part of care team, but close connection and communication with providers is essential
Nurse Practitioners	☒	☐	Chronic disease education and management; medications education and management; collaboration with PCP's to address medications concerns or duplicative med's;
Patient Navigators	☒	☐	Useful for navigating inpatient admissions, or specialty care (Cancer Center, etc.)
Peer Advocates	☒	☐	Local resources exist for which clients can be referred out
Promotoras	☒	☐	Same as above
Psychiatrists	☒	☐	Access to consultants when needed is useful
Psychologists	☒	☐	We have seen the most need for Neuro-Psych evals for out clientele (for both children and adults)
Registered Nurses	☒	☐	Chronic disease education and management; medications support
Social Workers	☒	☐	Generalist approach for client-centered work;
Wraparound facilitators	☒	☐	Could be met by above disciplines
Other	All of the fields listed above can be useful, but configuration should depend on community needs. At the very least, we have found CACs, LCSWs or other behavioral professionals, nurse practitioners, and Case Aides/Community Health Workers to be essential.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☐	MACC has a 'Nurse Home Visit' program embedded in its team that sees solely newborns/infants – can be referred to other staff if ongoing needs are present
Children	☒	☐	MACC has a 'Healthy Harbors' program embedded into its team, that serves high-risk children who have DHS/CPS involvement
Children who are healthy, but in socially-complex environments	☒	☐	Yes – within the MACC team, Healthy Harbors addresses and serves this population – a family systems perspective here is imperative
Children involved in the foster care system	☒	☐	Yes – within the MACC team, Healthy Harbors addresses and serves this population
Children with a chronic illness	☒	☐	Yes – within the MACC team, Healthy Harbors addresses and serves this population
Children with a serious emotional disturbance	☒	☐	Yes – within the MACC team, Healthy Harbors addresses and serves this population
Children with medical complexity	☐	☐	MACC serves both children and adults with high medical complexity
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	Yes – within the MACC team, Healthy Harbors addresses and serves this population
Transition-age adolescents	☒	☐	Yes – within the MACC team, Healthy Harbors addresses and serves this population
Parents and families	☒	☐	Although MACC will have a primary 'identified client', consideration must be given to the family system and the environment
Pregnant women	☒	☐	Esp. high-risk pregnancies
Adults	☒	☐	MACC focuses on high-complexity, high-risk, high-acuity adults
Adults who are healthy, but in socially-complex situations	☒	☐	MACC focuses on high-complexity, high-risk, high-acuity adults

Adults with a chronic illness	☒	☐	MACC focuses on high-complexity, high-risk, high-acuity adults – focus on managing chronic conditions is a priority for our program
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	MACC focuses on high-complexity, high-risk, high-acuity adults – BH or substance use disorders are common in our clientele
Clients involved in the criminal justice system	☒	☐	Inter-systems navigation needed
Clients with a disability	☒	☐	Many ACC members have disability determinations
Clients in a nursing facility	☐	☒	This has been a group that had been excluded in passive enrollment in the ACC – generally, the facilities are responsible for management of the pt
Elderly clients	☒	☐	If the patient has medical / mental health needs, or multiple conditions for which they need support
Frail elderly clients	☒	☐	If the patient has medical / mental health needs, or multiple conditions for which they need support
Clients in palliative care	☐	☒	Possibly – although many Hospice and Palliative care agencies provide comprehensive services
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system? Locally, we have significant focus on this population through our "Healthy Harbors" program which is embedded on the MACC team. In general, the RCCO continuing to develop relationships with county DHS offices that serve this population would be beneficial. Also, considering this population as equally high-priority for services from a preventative perspective would be prudent. Many foster children tend to have poorer health or behavioral outcomes than the mainstream child population – so early intervention and prevention could prove to be a cost saver in the long run.

19) How should care coordination be evaluated? How should its outcomes be measured?

Both quantitatively (i.e. ED or utilization reduction; cost reduction; avoidable cost reduction, etc.), and also qualitatively (client feedback – how did program participation positively impact the client's situation or ability to manage their conditions, access to resources, etc.).

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services? unknown

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population? Perhaps there should not be 'requirements'; 'guidelines' may be more useful. Some clients have extreme, long-term needs, while others have resource-related or shorter term needs. Clients with significant behavioral issues often have long-standing habits that are difficult to impact over time, and merit longer-term involvement. There is no 'one size fits all' staff to client ratio that works – it is depending on a staff's caseload mix by client acuity or level of need.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

MACC target caseload is approximately 50-60 clients per 1 staff; however, effective management of this caseload size is completely dependent on the level of need for each client. In contrast, we have a community program that serves co-occuring dual-disorder clients (with mental illness concurrent with substance abuse; that caseload ration is 12:1). For 'moderately intensive' to 'intensive' CC services, a target of about 50 clients has felt like a very full load. Also, clients require more work on the front end of their involvement in the MACC program, until situations stabilize or new resources are in place. In our initial research in creating this program, ratios above 1:80 were considered to be far less effective than ratios under 1:80 for moderately intensive to intensive care coordination.

Clients	
Fewer than 25	☐
26-50	☒
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐

More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important? Connection to other meaningful resources; stabilization of situations; reduction of inappropriate ED and other health services utilization (and related reductions in inappropriate costs); health improvement; client feedback regarding their experience and what has mattered most to them.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

See above

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

At minimum, a RCCO should be required to meet with the local oversight committee for MACC on a regular basis (at least quarterly), and to work directly with them on improving the approach and services for the community.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

Although this proposal might seem helpful for systems that cross RCCOs because it could help standardize their interactions (and therefore our input here diverges from that of one of our Oversight Committee members), we believe it could have very significant negative impacts. Here are the concerns raised by our Oversight Committee: It is possible that, if different players choose different RCCO's, it could eliminate the combined, coordinated approach that has worked very well in our community: the development of a highly-skilled transdisciplinary care coordination team (both embedded in our key clinics but also able to go anywhere needed) that includes significant capacity of carefully trained health, behavioral health, and social work professionals. As a community, we would experience an enormous loss if we are forced to lose the relationship we have with our current RCCO (Region 1: RMHP); hundreds (if not thousands) of hours have been spent in developing a model that is geared to the specific needs of this community and it would be a big blow to all participants to have to start over with another RCCO. It is important to recognize that our local primary care clinics have put a lot of time into figuring out a model that can work well (jointly) for them – they have agreed to pool their dollars specifically so that our impact can be greater than anything they could do alone. A local approach really needs their enthusiastic support, and it will be burdensome to them to change that model every few years. We are concerned in particular that constant change might lower the interest of the private clinics in participating in the project – and we desperately need every PCP willing to participate in Medicaid to participate. We are also concerned that this sort of change could result in PCPs choosing the RCCO that gives the most funding rather than the best overall approach, and that RCCOs would be forced to expend their resources competing for PCPs rather than developing excellent models of care. It seems that it would be nearly impossible for RCCOs to budget for such a scenario, because there would be a constant chicken-and-egg problem of not knowing how many lives they would have, yet having to tell providers what they are offering. Finally, we are concerned that such an approach would be highly likely to seriously fragment community approaches, which we believe have the best potential for providing effective overall

community care coordination. It is rare that any clinic is large enough to gain enough PMPM to provide the diversity of specialized assistance that we are able to provide on our team using pooled dollars, and we believe it would be an enormous loss to lose that. If we end up with more than one RCCO in a region, it is very hard to figure out how any sort of a community coordinated care coordination system could ever work. Our concern is that fragmented approaches in a variety of clinics may never achieve the potential of a well-organized community coordinated care coordination system.

27) Should the RCCO region maps change? Why or why not? If so, how?

NO - see above. In any change consideration, it's important that regional maps align with patient patterns in accessing care, and build upon natural partnerships. However, what that means in action differs according to the patient's needs, and there are no perfect boundaries. For example, in Larimer County, this project has evolved differently in northern Larimer County than in southern Larimer County, due to how patients access care, different hospital systems, and how the partners negotiated working together. While at first it seemed strange to separate Larimer County from Weld County, in the end, in order to be effective, our approaches needed to be adapted to the particular needs of the local community – which in our case, was smaller than a county, and has worked well in a community with a significant population.

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

While we don't know the exact number of months, we know that any transition, if it's a change in RCCO, will require very significant work locally, and hope that you allow a LONG transition time if we will be faced with change.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

Changes clearly allowing information-sharing

Adequate levels of a complete continuum of evidence-based substance use disorder treatment

Reduction in barriers to providing mental health services in primary care clinics

31) What are the limitations of the current benefit structure and what – if any – changes are needed? Medicaid has made great strides in coverage, including oral health care. However, we need to squarely address the need for parity in substance abuse services – including offering a full continuum of evidence-based treatment for substance use disorders (including intensive outpatient services and residential services).

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address? NO – please see our answer on #26. We believe this would only create a fragmented, duplicative response, confuse patients and providers and local care teams (not just Medicaid care coordinators, but all care coordinators), and create multiple / duplicative reporting structures that would be burdensome on local resources. Resources should continue to be focused on client services.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs? Allow for RCCO's to provide batch corrections / updates for client attributions and bypass the cumbersome HealthCO process

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services? Further development or working relationships with local DHS to serve high risk children

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado? Refer clients who are no longer eligible for Medicaid to Connect for Health Colorado and its assistance sites for help finding other health insurance in order to stay consistently covered.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC? Including all local organizations that have a stake in serving the Medicaid ACC population in planning and coordination efforts.

42) How should the Department structure stakeholder engagement for the ACC as a whole? Be inclusive, proactive with agencies serving this population

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population? No

a. If no, what are the gaps? There are clearly shortages of psychiatric providers, which is a significant problem for this project. Both psychiatrists and psychiatric nurse practitioners are very much needed. Child psychiatric providers are needed, but so are adult providers. In our community, we need more PCMPs willing to accept Medicaid, more dental capacity, and there are often challenges accessing specialists.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program? Develop reporting on admits / ER visits for ACC members

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program? Serve more Medicaid patients – they are very much needed.

d. What role should home health play in the next iteration of the ACC Program? Education re: ACC enrollment and local care teams

e. What role should hospice care play in the next iteration of the ACC Program? Same as above

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program? They need to be integrally involved in the ACC MMP; that program can't succeed without their cooperation.

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program? Same as above (education)

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past? Same as above (education)

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP? Should not require, but could facilitate development of this.

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed [you left out the option of "on staff at community care teams"

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☒
On staff (salary) at RCCO	☒

Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

If you were going to require this, you would probably need to compensate RCCOs (and dentists) more – that is a tall order.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you? (Sorry; have run out of time to answer this well)

b. What RCCO requirements would ensure cultural competency? Trainings, etc.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

Bi-lingual staff, interpreters, culturally competent staff, staff with time to interpret complex health instructions, nurse health educators, etc.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Target super-users as MACC is doing; address the root causes of severe behavioral health issues, including addictions.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support: deferred

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

Moving towards global payment (real global payment, where there is flexibility to address the biggest local needs differently) and away from FFS seems promising. Change the BHO capitated/FFS model to a real capitated model, or include allowable claims for care coordination, substance abuse, psychiatric or therapist consultations without the patient present, telehealth, etc. Pay for adequate levels of substance abuse treatment.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience: qualitative interviews / surveys

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

Not clear if you mean the whole population, or the Medicaid Population. You could utilize BRFS or BRFS-like random sample surveys of Medicaid clients, adding appropriate questions for the biggest needs for intervention. Locally, you could use BRFS data, or local community assessments (we have some comprehensive ones). Thank you for recognizing that you can't adequately measure population health through claims data!

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public? To the RCCOs and PCMPS, with targeted charts and reports. To the public, through public meetings, press, etc.

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible. deferred

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐

31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Probably should use the same KPIs. However, KPI development shouldn't change every year, and needs PCP buy-in: to make real differences in KPIs can often take serious practice transformation.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐

Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO: deferred

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below: deferred

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☐
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

In our community, the practices find that they need the help of a population health analysis to help them boil the information they are receiving down into sound bites that they can act on.

81) How can Health Information Technology support Behavioral Health Integration?

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful. There should definitely be the continuation of a service such as SDAC.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful. We have found that there are many basic elements that need to be included, but that it is hard to require a shared tool due to the multiplicity of HIT systems used by different clinics.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

FREQUENT updates; notice of who is currently open to new clients; easy to use; not confusing; helps sort out relevant providers (location, specialty, ages accepted, etc.) with ease. Significantly improving your current directory would be an awesome help statewide (and you might be able to get grants to do it!).

86) How can the RCCOs support providers' access to actionable and timely clinical data?

In our case, RMHP has developed monthly reports that are wildly helpful. They need access to VERY timely claims data in order for it to be helpful for our actions.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used. Wonder if it would be possible to create a comparison of services used/costs over time for individuals, practices, and communities?

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

Our practices have requested a population health analyst. Our RCCO is also very good about running specific requests for data when needed.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 104

Accepted by: KJDW

Notes: Formatting standardized

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Ayelet Talmi
Location: Denver CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Children's Hospital Colorado
Location: Aurora, CO
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Integrated behavioral health provider
  ii. Area of practice: psychology
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☒ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Involvement as a provider in a system of care; practicing integrated behavioral health within primary care

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Mental health providers; serving on committees and advisory groups to improve access and quality of services to children and families within the Medicaid system in CO.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

My institution will seek to participate because we serve a high number of children with public insurance. My population of interest is children and families with public insurance and as a result, I will practice within an organization that aims to serve that population.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

Opportunities for integration of physical and mental/behavioral health in the context of primary care settings.

2) What is not working well in the ACC Program?

Capitation of mental health services that make providing preventative and health promotion services to children and families seen in primary care settings impossible. Lack of reimbursement for health and behavior codes that can be used to serve children with complex health needs whose behavioral health issues impact their ability to manage disease processes.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

Some BHO have integrated behavioral health services.

4) What is not working well in the BHO system?

a. No payment for prevention and health promotion activities
b. Diagnostic driven system that eliminates access to care for babies, young children and their families if there is no corresponding mental health diagnosis that allows for billing
c. Requirement to have pre-authorization before providing services
d. Referral form is long, cumbersome and way too complicated and convoluted to be completed in a primary care setting
e. Primary care providers get no information back from BHO/Community Mental Health Centers when our patients have evaluations or get services without a ROI. At the very least, some form of communication that a patient "arrived" in the mental health system would be essential to improve communication and care.
f. Community mental health centers with walk-in intake processes present a huge barrier to care for some of the families that require their services

5) What is working well with RCCO and BHO collaboration right now?

Some RCCOs have found ways to share data so that physical health and mental health records present a full picture of a person's well-being.

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Colorado should have universal access to integrated behavioral health services in pediatric and family medicine settings. Integrated behavioral health clinicians need to be trained in working not just with pediatric populations, but with infants and young children and their families. We need to maximize the potential to provide prevention and health promotion services. We also need practice innovations that will allow us to provide multi-generation services in the context of pediatric primary care without needing to enroll adult caregivers or bill on their insurance for services rendered to support families in creating and maintaining safe and supportive environments in which their children can grown and thrive. Provide funding for integrated behavioral health services that offer consultation and support to primary care health professionals in meeting the comprehensive health needs of the patients they see. This includes being able to utilize health and behavior CPT codes to bill when providing behavioral health services related to physical health issues (e.g., obesity). CO needs a workforce capacity development plan to ensure that we have well-trained, highly-qualified behavioral health professionals who can function well in primary care settings. Integrated behavioral health services have the promise and potential to expand the continuum of behavioral health services to create universal access to comprehensive, high quality health homes.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	
Community Behavioral Health Services Rule	☒	☐	
Covered diagnoses list	☒	☐	No prevention or health promotion services are funded
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	
PCMP financing structure	☒	☐	Not enough funding to employ integrated behavioral health clinicians
Per-member per-month amount	☒	☐	Too little money to incentivize PCPs to engage in the full range of behavioral health screenings and supports needed in a health home
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☒	☐	Need to develop a competent workforces
RCCO or BHO contracts	☒	☐	Primary care settings see patients across BHO lines; credentialing; authorization; contracting variabilities
Staff capacity	☒	☐	Need more trained integrated behavioral health clinicians – not more co-located mental health providers
State/Federal rules or reporting requirements	☐	☐	

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Technical resources / data sharing	☒	☐	Need behavioral and physical health data to be compatible in order to track outcomes over time
Training	☒	☐	Too few trained integrated clinicians
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

A clinic that provides Integrated behavioral health services that are comprehensive is providing screening, identification, triage, consultation, referral, and brief treatment services to a patient and her/his identified caregivers. The services are universally accessible and not driven by diagnoses. Preauthorization is not required. Behavioral health clinicians are a part of the care team, engaging in treatment planning and decisions, providing care, and supporting primary care professional in managing patient care. The services are not co-located. Co-located services replicate outpatient mental health services and essentially significantly limit the bandwith of integrated clinicians to provide care. With co-location, behavioral health clinicians have set appointments, work out of an office space that may or my not be a primary care settings, and do some sharing of patients but provide traditional mental health services.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

There are model programs around the State that are providing high quality integrated care. These programs could benefit from funding and attention that will enable them to expand their capacity to disseminate.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

b. How should RCCOs prioritize who receives care coordination first?

A tiered approach, like the one used in public health services, would be ideal. All families should be entitled to basic care coordination resources with higher levels of need dictating more intensive care coordination.

c. How should RCCOs identify clients and families who need care coordination?

Having a statewide, accepted system for identifying client needs for care coordination would enhance the ability of RCCOs to provide targeted levels of care coordination to clients with varying degrees of need. Functional impairment, behavioral functioning, quality of life, and existing resources and supports should all factor in to the assessment of care coordination needs.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

Shared data systems and strategic use of information technology should aid with tracking care coordination practices. Alternatively, billing codes for care coordination could be leveraged to track effort.

12) What services should be coordinated and are there services that should not be a part of care coordination?

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☒	Provide services that span prevention, health promotion and intervention
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	Coordinate and help to centralize information and resources in the community; direct clients to the right access point
Daycare / childcare	☒	☐	☒	Coordinate and help to centralize information and resources in the community; direct clients to the right access point
Economic stability & employment	☒	☐	☒	Coordinate and help to centralize information and resources in the community; direct clients to the right access point
Education	☒	☐	☒	Coordinate and help to centralize information and resources in the community; direct clients to the right access point
Environment	☒	☐	☒	Coordinate and help to centralize information and resources in the community; direct clients to the right access point
Food access / nutrition	☒	☐	☒	Coordinate and help to centralize information and resources in the community; direct clients to the right access point
Health literacy	☒	☐	☒	Provide training to clients and to providers around health literacy matters
Housing	☐	☐	☐	Coordinate and help to centralize information and resources in the community; direct clients to the right access point
Language or translation services	☒	☐	☒	All clients should have access to care and information in their language of choice

Literacy	☒	☐	☒	Coordinate and help to centralize information and resources in the community; direct clients to the right access point
Transportation	☒	☐	☒	Coordinate and help to centralize information and resources in the community; direct clients to the right access point
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	
Certified Addiction Councilors	☒	☐	
Certified Nurse Midwives	☒	☐	
Community Health Workers	☒	☐	
Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☒	☐	
Licensed Mental Health Counselors	☒	☐	
Licensed Professional Counselor	☒	☐	
Masters of Public Health	☒	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	
Nurse Practitioners	☒	☐	
Patient Navigators	☒	☐	
Peer Advocates	☒	☐	

Promotoras	☒	☐	
Psychiatrists	☒	☐	
Psychologists	☒	☐	
Registered Nurses	☒	☐	
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☒	Prevention and health promotion services; understanding their environments and coordinating care for their caregivers
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☒	☒	
Children involved in the foster care system	☒	☒	
Children with a chronic illness	☒	☒	
Children with a serious emotional disturbance	☒	☒	
Children with medical complexity	☒	☒	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☒	
Transition-age adolescents	☒	☒	
Parents and families	☒	☒	
Pregnant women	☒	☒	
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☒	☒	
Adults with a chronic illness	☒	☒	
Adults with a behavioral health diagnosis or substance use disorder	☒	☒	
Clients involved in the criminal justice system	☒	☒	
Clients with a disability	☒	☒	

Clients in a nursing facility	☐	☒	
Elderly clients	☐	☒	
Frail elderly clients	☒	☒	
Clients in palliative care	☒	☒	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

a. **Care coordinator to client ratios**. If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐

1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Universal screening processes that include screening, identification, and triage based on identification

Data reporting to providers regarding client outcomes and, in particular, data sharing around behavioral health service uptake in the community.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

PCMP are best suited to determine which RCCOs they want their clients to enroll with as these providers know their communities of practice best and are best-suited to determining what services and supports their clients require.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

The BHO regions should mirror the RCCO regions and should have the flexibility to accommodate care across regions (e.g., care that is provided in the context of an integrated behavioral health services program).

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

At a minimum, RCCOs should have mandatory advisory board with representation from the above in their region. Depending on the region and population being served, the provider/community advisory board composition will differ. The advisory board should have decision-making power and significant influence in how the RCCO choose to implement programs and services.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

No. Huge mental/behavioral health gaps and service needs and a lack of continuum of care in behavioral health – no attention to health promotion and prevention efforts and inadequate attention to early childhood needs.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

Yes. CHW and PN are essential service providers in a system of care that seeks to impact the comprehensive health and well being of a population.

47) **Community Health Worker reimbursement**. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☒
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Provider and member training and resources around Health Literacy.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☒
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☒
Provide clinical screening tools	☒	☐	☒	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☒	☐	☐	☒
Provide registries	☒	☐	☐	☒
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☒	☐	☐	☐
Supply behavioral health surveys	☒	☐	☒	☐
Supply other self-screening tools	☒	☐	☒	☐
Administer behavioral health surveys	☒	☐	☐	☐
Administer other self-screening tools	☒	☐	☐	☐
Prepare client action plans	☒	☐	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☒
Provide training to supporting staff	☒	☐	☐	☒
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☒	☐	☐	☒
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☒
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☒	☐	☐	☒
Provide standing pharmacy order templates	☒	☐	☐	☒
Provide comprehensive directory of community resources	☒	☐	☐	☒
Provide directory of other resources	☒	☐	☐	☒
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☒
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

no

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☒
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Yes.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Yes if the national standards take into account local implementation.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☒	☐
Shared decision-making tools	☐	☐
Telemedicine software	☒	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☒	☐
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☒	☐	☐
Health risk assessment software	☐	☐	☐	☒	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☒	☐
Patient education wellness tools	☐	☐	☐	☒	☐
Provider/case manager directory	☐	☐	☒	☐	☐
Shared decision-making tools	☐	☐	☒	☐	☐
Telemedicine	☐	☐	☒	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Costs and inability to share across systems

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 105

Accepted by: KJDW

Notes: Applied standard formatting

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Jordana Ash
Location: Denver, Co

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: CO Dept of Human Services/Office of Early Childhood
Location: Denver, CO
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☒ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☐ Yes
☒ No

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
I previously worked at a mental health center & we interacted with the RCCO in our area

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
I oversee the Early Childhood Mental Health Specialists program & those positions are located within the Community Mental Health Centers which provide services to Medicaid clients.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☒ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

2) What is not working well in the ACC Program?

3) What is working best in the Behavioral Health Organization (BHO) system right now?

   Some BHOs are supporting extensive child teams that have a combination of clinic and community based services. We should look to those BHOs as examples of what a continuum of care can look like for child & families.

4) What is not working well in the BHO system?

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Behavioral health services should be widely available at all primary health care clinics. Provision of behavioral health care, including routine screenings for mental health & developmental issues should be provided at the universal level, with care coordination and other forms of intervention available as needed. Family centered care will require strategic thinking about policies & financing that reflects the care being provided, but is our best approach to ensuring healthy development of all children, which in turn will reduce long term physical and behavioral health costs to adults.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	CMHC do not currently have mechanisms to pay for prevention services, which are critical when concerning early childhood mental health.
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☒	☐	Mental health services for young children need to include a primary caregiver and thus we need family or relationship diagnosis to be developed & covered.
Different behavioral / physical health reimbursement	☒	☐	Behavioral health, i.e. strong mental health & wellbeing are inextricable from physical health. We know that there are physical health implications for those with behavior health problems and thus we need parity in terms of reimbursements.
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☒	☐	This barrier can impede the introduction & delivery of integrated behavior health services in primary care facilities.
Privacy Laws (HIPAA, 42 CFR)	☒	☐	HIPAA considerations are of utmost importance but can be addressed so that care coordination can be achieved in a more efficient, effective manner.
Professional / cultural divisions	☒	☐	Stigma continues to surround mental health issues. Clients will benefit from understanding that routine care involves care & consideration of these issues. If this question relates to a professional divide between physical & mental health providers, there are numerous examples to draw on to show the added benefits of having behavioral health services readily available in practices.

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

RCCO or BHO contracts	☒	☐	Even with fee for service options, the BHO system is not readily set up to understand the mental health needs of young children whose issues need to be considered in the context of relationships. Whole family care is critical.
Staff capacity	☒	☐	We need more investment in building a workforce ready to serve behavioral health needs in physical health settings. Early/ young child mental health is a specialty & we need to devote resources so that practitioners have the skills they need to assist families competently.
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☒	☐	Data sharing is a complicated, multi-faceted issue and will take concentrated planning and commitment to a solution.
Training	☐	☐	
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

- Recognize the focus needs to be on health/mental health prevention, promotion & early identification of problems, not disease model treatment
- Whole family meets practice transformation to recognize child & parent each influence the well-being of the other
- Metrics needs to be aligned with family well- being.
- Practice change to recognize psychosocial factors impact on health outcomes

Care Coordination

11) Care coordination is an important part of the ACC Program.

   a. What is the best definition of care coordination?

   b. How should RCCOs prioritize who receives care coordination first?

   c. How should RCCOs identify clients and families who need care coordination?

   d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

   a. What care coordination is going on today?

   b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

   c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

   d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☒	These children are especially vulnerable & at risk for long term physical & mental health issues. Ensuring proper developmental and mental health screenings are completed at recommended intervals is critical.
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	Navigation to other resources or direct assistance will ensure lower population costs as patient will more likely be successfully treated if cost barriers are removed.
Daycare / childcare	☒	☐	☐	If not a direct support role, understanding the role child care as a protective factor or a risk factor (poor quality, long hours, risk of expulsion) is important to overall health & wellbeing
Economic stability & employment	☒	☐	☐	As above, understanding stress and risk associated with family status is an important aspect of care
Education	☒	☐	☐	As above
Environment	☒	☐	☐	As above with special consideration to advent of toxic stress on development
Food access / nutrition	☒	☐	☐	Absolutely
Health literacy	☒	☐	☐	First level population health activity
Housing	☒	☐	☐	Potential risk
Language or translation services	☒	☐	☐	Health care is culturally bound. Beyond translation, we need cultural brokers to genuinely achieve health equity & family centered care.
Literacy	☒	☐	☐	Another universal activity best delivered where patients come.
Transportation	☒	☐	☐	Health equity issue. Care coordination can cover this issue

Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☐	
Children	☒	☐	
Children who are healthy, but in socially-complex environments	☒	☐	
Children involved in the foster care system	☒	☐	
Children with a chronic illness	☒	☐	
Children with a serious emotional disturbance	☒	☐	
Children with medical complexity	☒	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	
Transition-age adolescents	☒	☐	
Parents and families	☒	☐	
Pregnant women	☒	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☒	☐	
Adults with a chronic illness	☒	☐	
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	
Clients involved in the criminal justice system	☒	☐	
Clients with a disability	☒	☐	
Clients in a nursing facility	☒	☐	
Elderly clients	☒	☐	
Frail elderly clients	☒	☐	
Clients in palliative care	☒	☐	
Other populations, please comment: It seems to me that each of these populations will need to be served by a generalist with a good command of navigation, resources, and the interplay of health & mental health. Each sub-specialty will also require a depth of knowledge about the unique issues to be considered when providing coordination. Pregnant women, and infants/young children do require special knowledge and attention to the incredible development that is underway in this time period.			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

    a. What is the PMPM cost for providing care coordination services?

    b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

    a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

The ACC program should continue to work with CDHS to stay informed of our programs & priorities. In this manner, opportunities for collaboration, shared programming, and greater outreach to clients can occur routinely.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

   a. If no, what are the gaps?

   b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

   a. What role should hospitals play in the next iteration of the ACC Program?

   b. What role should pharmacies play in the next iteration of the ACC Program?

   c. What role should specialists play in the next iteration of the ACC Program?

   d. What role should home health play in the next iteration of the ACC Program?

   e. What role should hospice care play in the next iteration of the ACC Program?

   f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

   g. What role should counties play in the next iteration of the ACC Program?

   h. What role should local public health agencies play in the next iteration of the ACC Program?

   i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☒
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Workforce development & support of training to increase capacity of navigators as part of care team.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☒	☐	☒	☐
Provide health and functioning questionnaires	☒	☐	☒	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☒	☐	☒	☒
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☒
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☒	☒
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

When there is a desired for consistency across the state in terms of survey/consumer experience information that is being collected, the state should provide these types of surveys.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience**. Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here. Not familiar enough with all those surveys to comment		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment**. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	

10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☒
Digital care management tool	☐	☐
Care transitions alerts	☐	☒
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☒
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☒
Provider/case manager directory	☐	☒
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the 5DAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☒	☐	☐	☐
Care transitions alerts	☐	☐	☐	☒	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☐	☒	☐	☐	☒
Health risk assessment software	☒	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☒	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☒	☐	☐
Patient education wellness tools	☐	☐	☐	☒	☐
Provider/case manager directory	☐	☐	☐	☒	☐
Shared decision-making tools	☐	☐	☐	☒	☐
Telemedicine	☐	☐	☒	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Time it takes to use the analytics capabilities

81) How can Health Information Technology support Behavioral Health Integration?

There are many ways; prompts about behavioral health screenings, information & resources, ready access to psychosocial elements of care.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 106

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Kathi Wells & Bill Betts
Location: Statewide

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Program to integrate healthcare for children in foster care
Location: Statewide
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Pediatrics
  ii. Area of practice: Foster Care
☒ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?
☒ No

If you answered "yes" above, how long?
☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Developing healthcare services for children in foster care all of whom are enrolled in RCCO

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Historically majority of services are paid through Medicaid fee for service. Have integrated behavioral health services into practice but experiencing barriers to behavioral health funding that are not seen for physical healthcare.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?
☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

We have no choice if we are going to serve this population.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

Historically, children foster care have frequent moves between healthcare providers with inadequate sharing of healthcare information. It was mandated that the RCCOs specifically address the healthcare needs of children in foster care. Therefore the promise of RCCOs, is that they can ensure children in foster care receive the specialized healthcare services that need, which the RCCOs can demonstrate through data on outcomes. RCCOs can assist in the development of a consistent medical home for these children, who have complex healthcare needs because have the ability to coordinate and direct where children in foster care receive services. However, it is currently unclear whether this potential is being realized consistently across the state.

In general, reimbursement (mostly due to the Federal ACA) is fairer now.

The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start. **Additionally, the American Academy of Pediatrics has recommended an accelerated schedule well child visits for children in foster care which is not captured by the current KPI's.**

The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid **especially for children in foster care**. Thank you.

The ACC Program is a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should not be considered one of the subgroups. **Additionally it provides an opportunity to create a system which can ensure that children in foster care receive the level of care that they need.** The following principles should be incorporated into the core objectives of the ACC:

- Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases. **This is especially important for children in foster care that often have not previously received necessary well child care and often have greater risk for untreated/unidentified health (physical and behavioral) problems.**
- Provided the ACC Program's desire to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.
- The ACC will need to invest in children to the extent possible now even though the savings come much later. We support the concept that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
- **Generally, it is difficult to help children unless assistance is provided to the family. This becomes even more complex for children and youth in the foster care system as DHS plays a role in**

assuring their care but does not have the resources or knowledge to address the healthcare needs of these children. For these reasons, care coordination is more involved for children since it includes care coordination of the parents/guardians/family.

- There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level.

2) What is not working well in the ACC Program?

It is unclear whether the ACC has provided guidance to the RCCOs on how to manage the unique healthcare needs for children in foster care. Many times there are a number of individuals (foster parent, child welfare case worker, guardian ad litem/courts) that have a role in ensuring that children get the healthcare that they need. Often RCCOs lack the infrastructure to ensure all parties are provided with the information that they need. While the RCCOs have care coordinators, these individuals are sometimes unaware of how the child welfare system functions and which individuals need to be contacted under specific situations. In addition some parts of the state, specialized services have been developed for children in foster care however the attributing process is often unaware of these services. Therefore, children foster care are not able to benefit from these resources. Also, some children in foster care experience frequent moves. The ACC system is not well designed to address information sharing when children move between providers and/or RCCOs.

Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family. The attribution process does not work at all for children in foster care as children are attributed to a medical home that no longer reflect their situation and that attribution is not adequately communicated to DHS or the foster parent. Additionally, the attribution process often limits access to necessary services to children in foster placement.

The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs as well as DHS/the child welfare system and foster parents of children and youth served by the ACC Program. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. Additionally, this is particularly challenging if a child in foster care is from one region but is placed in a foster home in another region or is moved between regions. This is particularly true in the Denver metro area. <u>There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. **Additionally, there should be consideration of one RCCO for all children and youth in foster care.**</u>

The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

RCCOs are not providing the level of care coordination that Medicaid patients need, **including for children in the child welfare system. Most DHS workers/foster parents know nothing/very little about the ACC program including how to benefit from any level of care coordination. Additionally, the RCCOs seem to know very little about the child welfare system/needs of children in foster care.** The level of commitment that patients and families need in general is difficult to find, unless care coordination is provided at the medical home level or the community level.

Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. In the new RFP, it is important to address how RCCOs will consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement.

The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs as **well as movement of children and youth into and out of the foster care system as well as between different RCCO's while in the foster care system.** Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices to be open to the more complex and challenging patients, those that likely need access the most. **While foster children are clearly complex and in some ways may need these services the most, they are rarely cared for within the same practice for a long period of time and it is difficult to support and incentivize practices to provide the necessary level of care that they so greatly need.**

Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

This varies between BHOs. For example Access Behavioral Health makes it easy to contract for behavioral health services.

4) What is not working well in the BHO system?

In some areas it is difficult to contract for services (especially for specialized care- which is often needed for children in foster care). In some areas this means developing a single case agreement which can take up to 3-4 weeks. In other areas, BHOs refuse to contract for services. This is especially problematic for children in

the child welfare system since they may enter the system in one area and get placed in a foster home in another. This means that which BHO is responsible can be difficult to determine.

5) What is working well with RCCO and BHO collaboration right now?

It is not clear what is working well. This does not mean that nothing is working, just that it is not clear to providers in the community.

6) What is not working well with RCCO and BHO collaboration right now?

Since medication is managed by one system and psychotherapy is managed by another, there is often a disconnect between these two closely related services. Additionally, the BHO and RCCO areas are different. This is further complicated by the fact that they do not overlap with areas for other parts of the system (such as judicial districts). This causes difficulty and confusion when trying to determine which agency to contact.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

To effectively promote the integration of behavioral and physical (medical) health care in Colorado, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care. **This is especially important for children in the child welfare system that are often receiving physical and behavioral health services in different regions creating even more complexity for already confused DHS workers and foster parents.**

The behavioral health and wellness codes (96150 – 96155) need to be opened as son as possible as this will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

Care coordination for both behavioral health and medical care should be done in the primary care setting. **This is also aligned with recommendations for the best healthcare of children in foster care.** Either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. Behavioral health care coordination and medical care coordination needs to be fully reimbursed and the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues **such as for children in foster care.**

We recommend providing an infrastructure and funding for data collection and management to support integrated behavioral health in the medical home as well as the care coordination that would have to be part of that. Utilizing 5DAC data is just one way to understand the activities within a medical home. 5DAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the

[1] Many terms and definitions can be found in the Appendix at the end of this document.

development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

The C-PACK program developed by CBHC is a very good program, particularly the following:

a. Assistance with finding a behavioral health provider for patients
b. Telephone consultation by a child psychiatrist to primary care providers

We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

b. How should RCCOs prioritize who receives care coordination first?

c. How should RCCOs identify clients and families who need care coordination?

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), **collaboration with foster care and DHS system (there may need to be support outside the medical home, though, to assist in information sharing of foster children that are being moved from placement to placement).** RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	
Health literacy	☐	☐	☐	
Housing	☐	☐	☐	

Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	
Transportation	☐	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	**Coordinate care?** **Yes**	**No**	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	

Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	
Wraparound facilitators	☐	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations**. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	

Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

Regarding children in the foster care system, RCCOs need to understand the complexities of the child welfare system and address the challenges of creating a medical home for these children while they are in placement. This needs to include assisting in the collection and sharing of critical health information on these children. There should be some consideration of an additional pmpm reimbursement for those providers willing to understand the unique needs of these children and take on their care.

19) How should care coordination be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient/parent/caregiver behavior, or practices will again be less likely to serve those with highest risk. **This is especially challenging for children in the foster care system who often enter the system with inadequate health care, that may move from location to location and from foster home to foster home with an already overburdened child welfare system as the responsible custodian to collect and share information. This puts an additional burden on the healthcare provider to be able to show their effectiveness under the current strategies and may deter them from caring for these challenging children who need the consistent care the most. The effectiveness of the medical homes willing to care for children in foster care should be measured by good practices, such as those that can be defined by elements already established (AAP and Child Welfare League of America). Adherence to these elements could be used to evaluate the effectiveness of these practices in caring for this population.**

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Many medical homes **(including those caring for foster children)** relate to multiple RCCOs and want to be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, and could receive a pmpm from all of them, which would enable them to afford to hire enough care coordinators to meet the needs of all of ACC patients.

Where should care coordination be done? Care coordination is best done in the medical home. Medical homes are generally willing to do care coordination (it is part of general medical care), because they usually have a relationship with their patients who trust them. **This is somewhat challenging for children in foster care, though, and additional support for care coordination of these children may be needed.**

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service. **Again, due to the additional complexities of children in foster care, there may need to be consideration of either outside support or an additional PMPM support for practices willing to and capable of addressing this issue internally.**

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They should include PCMPs in developing those criteria.

All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

There should be consideration of a single RCCO serving all Colorado children in foster care OR a clear plan outlined in the RFP by the RCCO regarding how they would manage this population including collection of health history, attribution that takes into account the unique circumstances and a plan for communication of medical information between PCMPs and RCCOs/BHOs when children and youth move in placement. Also, there needs to be a clear plan for the child's healthcare when they leave placement and potentially leave the ACC Program.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. For many expectations/requirements and ways of doing things the RCCOs are so different from one another that it requires significant extra work for medical homes to adapt to the differences. In addition, if a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. **This may also need to apply to DFS and children in the foster care system. Children are often from one region and then placed in another region or are moved between regions and therefore are having barriers and delays to timely and necessary healthcare services.**

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County
- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

Again there needs to be special consideration for children in foster care, potentially one RCCO for all children in foster care in Colorado.

28) Should the BHO region maps change? Why or why not? If so, how?

To seriously promote the integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated so that the regions are the same and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. Therefore, the BHO maps/regions should conform to the RCCO regions/maps.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area and for children in the foster care system.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

For children in foster care, they are attributed to their previous provider but then may be placed in another area or be expected to see a healthcare provider with special services targeted toward children in foster care but may have significant delays getting these services initiated due to the attribution process. For other children, RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home. There may also need to be a process for county DHS to provide such a list to the RCCOs for children in their custody.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

There needs to be significant training for both agencies and better established policies and procedures to work to address the needs of children in foster care. There have been some efforts in this area, but there is still a significant level of confusion on both sides of this issue. Additionally, foster parents remain very confused.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

Foster parents, the courts and guardian ad litems need to be included in the stakeholder process for children in the foster care system.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 107

Accepted by: KJDW

Notes: Added comment to response worksheet

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Moe Keller
Location: City, County, State.

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Mental Health America of Colorado
Location: City, County, State.
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☐ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Click here to enter text.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

☐ 3-4 years
☐ Since before the program was implemented.

General Questions

Page 14 mentioned specific populations, including individuals who have contact with the criminal justice system. I would like to see more opportunities for diversion programs, which could reduce the times and costs of an individual with mental health or substance use disorders within the jail or potentially prison system.

Judges have expressed frustration that there are not enough, or any, community programs for which a person eligible for diversion can attend and comply. Any way that these treatment programs can be folded in to the RCCOs would be a great benefit to all.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 108

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

CAAP

Colorado Association of Addiction Professionals

If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Understand the exact nature and treatment of the OP SUD & MH services, which provides them, and how to engage those resources. I have seen scant evidence of PCP/PCMP awareness of this, and thus high reluctance to "integrate" a provider into their patients' treatment.

Please share any other general advice or suggestions you may have about behavioral health integration.

Heavy medical orientation, with "What IS behavioral healthcare" being the dominant theme, legitimately. I've now spoken with 45 PCMP's and the overwhelming questions they ask are:

1. *What is your scope of practice?*
2. *What are your treatment modalities?*
3. *How do I find the right provider? Condition, culture, location, services...*
4. *How do I engage a BH provider?*
5. *How is case management and privacy issues addressed?*

Every one of these represents a barrier to benefits being utilized by beneficiaries.

What are the limitations of the current benefit structure and what – if any – changes are needed?

Overwhelming orientation toward "We will remove every possible way you could misuse funds from your business, and if there's anything left, you can use it for treatment" in some carriers' and BHO's policies.

Desiroble chonge would be to odopt o poyment policy on the order of "We trust to you try to treot your clients occording to your degrees, certificotions, licenses, ond experience ond will not second-guess your treotment recommendations nor put procedural controls in ploce before diagnosed treatments."

The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

While in theory it sounds like o good ideo, the odministrotion and poyment of provider claims is a very significant saurce of unexpected and unbudgeted odministrative costs, omplified by much confusion over the existing model. To offer o different program – independent of its foce volue – would likely drive the costs of odministering the progroms even higher, with commensurote unintended consequences.

Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Provide o statistic trocking mechonism, implemented ot the service provider level, ond coptured by EHR/PC ond EHR/BH systems. My compony is reody to support those meosurements todoy.

Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, behavioral health, or hospitals.

In oddition to oll above, there is not o cleor picture of the significont difference between the treatment protocols of primory core and of behoviorol heolthcore. This is reflected in the ossumption thot o "good EHR" will copture the case ond treotment monogement informotion for both. This is not the cose. Behovioral heolthcore hos mony porometers which ore not recorded, onolyzed, nor reported. Exomple would be "attendance level:" The foct thot o potient/client ottends "obove o 90% ottendance rote (for exomple)" is o mojor foctor in treotment efficocy.

What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

The educotion ond engogement model enumeroted above for PCMP's ond BHO's.

Please share any other advice or suggestions about provider support in the ACC.

Poy ottention to who provides treotment for ALL citizens, not just metro oreo and community clinics.

Additional comments from the Addiction Counselors.

What should be the next steps in behavioral health integration in Colorado? The powers that be need to expand the targets of integration. More individuals are seen by small providers than are seen at the community mental health centers. Right now the funding is focused upon community mental health and the big organizations. Small practices all over the State of Colorado should be brought to the table.

What care coordination is going on today? The focus is almost entirely upon the community mental health centers as I said and all the big players who are part of COPA. This is not the true voice of the provider community.

If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies). I have been to many RCCO meetings but so far I have seen little of what they do. After all the meetings I went to, they still didn't recommend my agency to someone I was already working with. That particular facility South Federal Family Clinic was actively visited by the local RCCO who did not mention us despite the fact that we are across the alley from that practice.

Please share any other general advice or suggestions you may have about behavioral health integration.

Widen the net of who is included in this process. Right now it is only the big agencies.

What are the limitations of the current benefit structure and what – if any – changes are needed?

Two local BHOs ABC and BHI are doing well. They are responsive to our needs and have an open dialogue with providers no matter how small. They are close to what OBH is asking and requiring of us and they honor our licensing provisions. They allow the clients and patients to get the treatment they need. They are good for the community.

Value Options (Foothills in Jefferson County) in the other hand tends to micro-manage, they parse out benefits and limit treatment based upon what appears to be financial criteria rather than what is best practices. They are almost impossible to communicate with and do not acknowledge our OBH licensing levels. They are not approving a full range of treatment levels despite the agencies being approved for higher levels of treatment. It took a full nine months to get approved by them as an agency and the work load associated with their payment is easily 3 times that of the other BHOs. They are out of touch in regard to what substance abuse benefits are and do not understand dual diagnosis or co-occurring disorders.

Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps? *The clients are having to wait up to 3-months for community mental health and the current network does not know about the smaller providers.*

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend? We need more behavioral healthcare intervention..

Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, behavioral health, or hospitals.

Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals? *Finonciol incentives go to big practices, ond to the physicions. Behoviorol Heolth core workers do not see this money.*

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 109

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

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NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Denver Health and Hospital Authority
Location: Denver, Denver, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Click here to enter text.
Location: City, County, State.
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ **Medical provider / PCMP / other provider**
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ **Yes**
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Denver Health is a PCMP for 4 RCCO regions, with an enrollment of approximately $20,000 RCCO members.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Denver Health is an integrated safety net delivery system and the largest Medicaid provide in Denver and all of Colorado. (See question #1 for more details on Denver Health's organizational structure and our patient population.)

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ **Very likely**
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

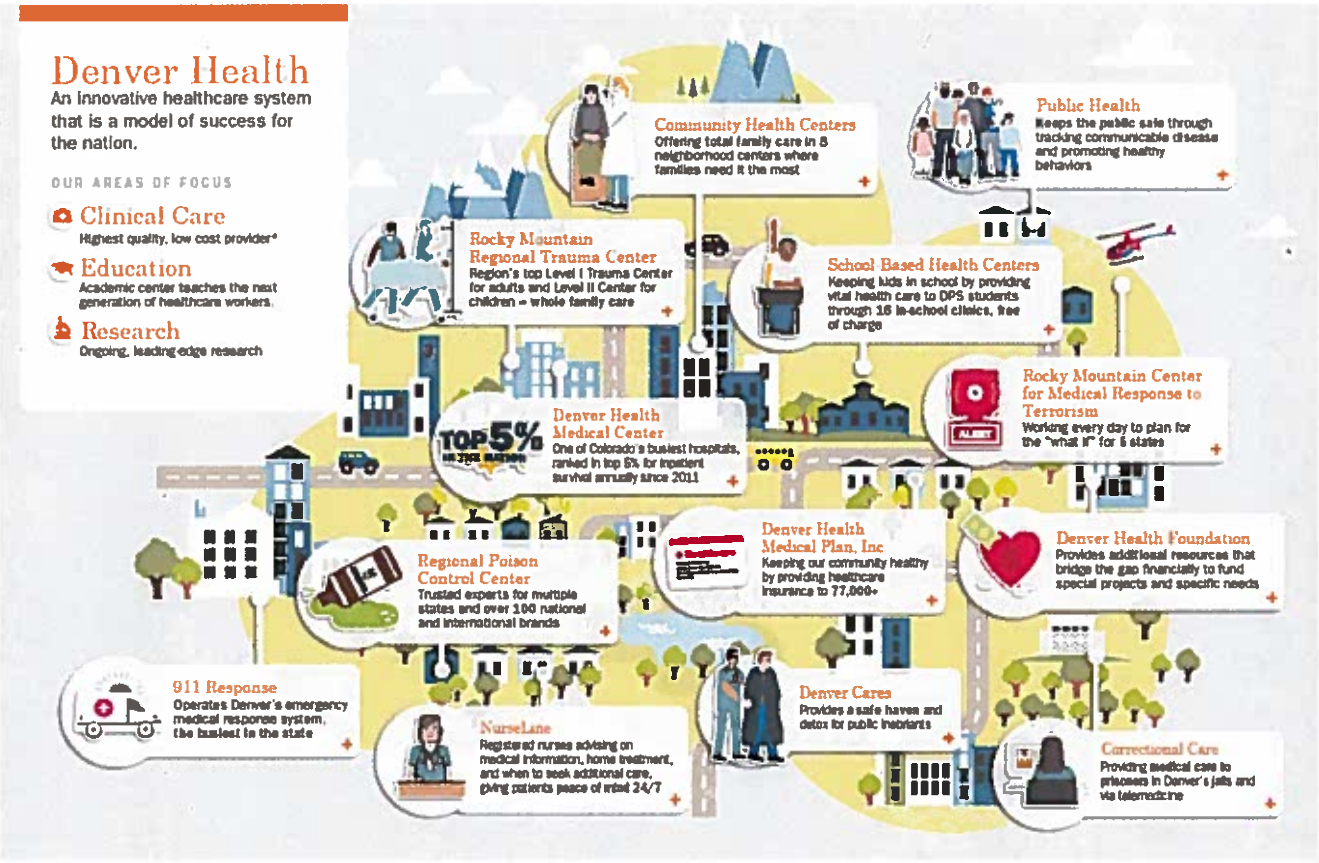
Please feel welcome to describe why or why not using the space below.

☒ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

Denver Health (DH) welcomes this opportunity to respond to the Health Care Policy and Financing (HCPF) Accountable Care Collaborative (ACC) Request for Information (RFI). DH is an integrated, safety net delivery system with a long track record of using Toyota Lean process improvement methodology to innovate.[i],[ii] DH is a medical neighborhood comprised of eight federally qualified community health centers; 16 school-based health centers; an ambulatory specialty care center; a 500-bed acute care hospital with a Level I trauma center; a 100-bed non-medical detoxification facility; the 911 emergency medical response system for Denver; a poison control center; a multi-lingual nurse line; correctional care services; an HMO that serves commercial, Medicaid, CHIP, Medicare and Medicare Special Needs patients; and Denver's public health department.



DH integrates components which are separate entities in most cities, meeting Halfon's criteria for a "community integrated health care system" and McClellan's criteria for an "advanced accountable care organization."[iii],[iv] The Commonwealth Fund has specifically identified DH as a "high performing public health care system", calling it a learning laboratory that has "succeeded at providing coordinated care to the community, promoting a culture of continuous quality improvement, adopting new technology and incorporating it into everyday practice, taking risks and making mid-course corrections, and providing leadership and support -- and accepting accountability -- both at the top and throughout the organization."[v] Across its diverse components, DH served nearly 186,000 individuals in 2013 (one third of Denver's population); delivered 37% of Denver's babies; and cared for 40% of Denver's children.

DH is also the single largest PCMP in RCCO Region 5. DH participates in four RCCO (Regions 2,3,5,6) with approximately 20,000 attributed RCCO members. Our RCCO membership combined with our Medicaid managed care plan (Medicaid Choice) membership of 24,000 adults and 41,000 children renders us the largest Medicaid provider in Denver and statewide.

The original ACC program (ACC 1.0) strengths are its focus on **medical home development and clinical integration** as well as **capacity building** for **population health and population-based payment.** The ACC 1.0 program design blended concepts drawn from the accountable care organization and medical home literatures to promote primary care practice transformation through improved care coordination and medical management, provider support services, as well as provider-level performance data. The RCCOs have successfully focused statewide attention on high risk/high utilizer patients. Colorado Access (RCCO Regions 2,3,5), in particular, has also been an effective convener, providing useful forums for PCMPs and other community providers to come together to discuss issues and best practices related to, for example, managing high utilizers, achieving behavioral health integration, and leveraging data available through the State Data Assistance Center (5DAC.) Most importantly from a DH perspective, the ACC has provided financial support for DH to further develop and refine both its primary care-based and centralized care coordination/management programs.

DH's participation in the ACC as a PCMP was coincident in time and strategically aligned with DH's $20 million CM5 Health Care Innovation Award to design and implement a population health approach to the delivery of ambulatory care services, called 21st Century Care (21cc). Briefly, 21cc explicitly defines an accountable population of 130,000 patients for which DH is -- or should be – providing comprehensive, patient-centered, primary care-based services. Using a combination of clinical and financial criteria, DH dynamically stratifies this population and identifies four broad categories (tiers) of care needs for adults and children. A graduated set of enhanced clinical and HIT services are matched to each risk tier and allocated according to individual patient needs within tiers, with more and higher intensity services reserved for higher tier patients. Services range from text message appointment reminders, to integrated behavioral health services, to complex care coordination and care transition support, to specialized, high-risk clinics for super-utilizers and children with special health care needs. Within its first year of implementation, 21cc has already demonstrated downstream cost avoidance.

Centralized care coordination/care management services are also available through our division of managed care and complement primary care-based services. Specific services include: complex case management, health coaching, peer support services, in-person and telephonic counseling services, ED diversion programs, and patient education/support groups. Many services are provided by telephone or in group settings. Managed care has established several intensive case management programs focused on individuals with complex needs and or who are making care transitions. It is common for the centralized and primary care based program staff to collaborate to provide care for the highest risk patients who often have a broad array of medical, behavioral, and social risk factors needing simultaneous attention. RCCO PCMP and care management delegation payments have been and will continue to be an important source of financing.

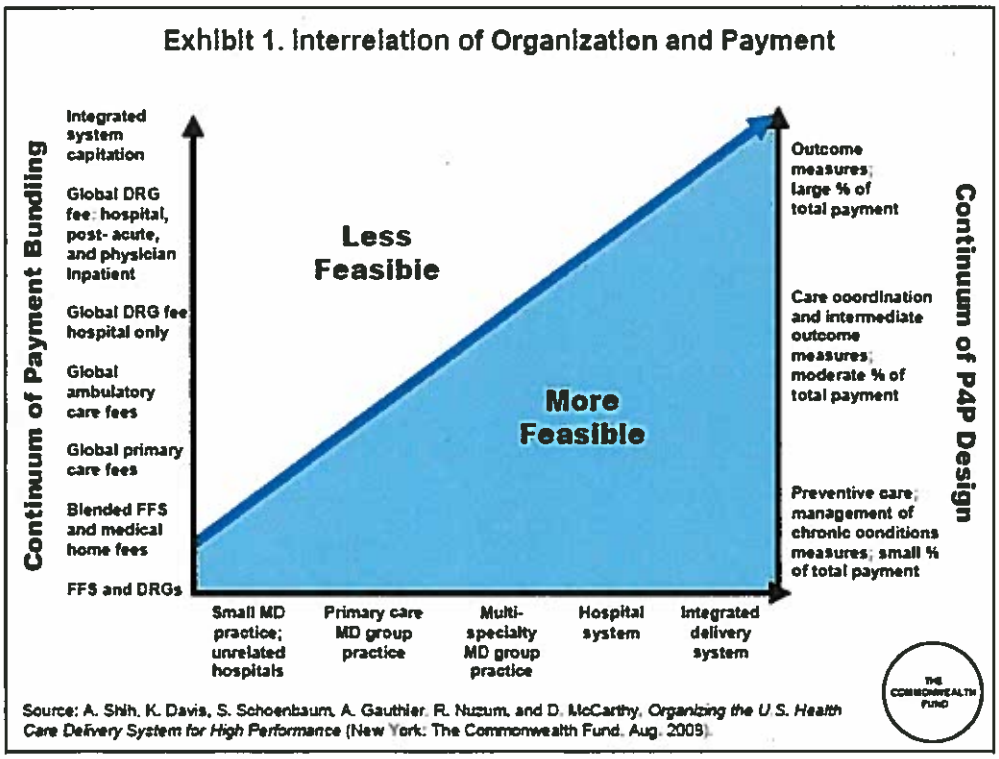
DH enthusiastically supports the vision for next RCCO RFP that emphasizes transforming from a medical model to a more comprehensive population health approach that provides whole-person/whole-family care, is responsive to community needs, and leverages unique community assets. Furthermore, we are pleased to see

the emphasis on exploring new payment models as we believe that the FFS payment model is the single greatest barrier to aligning financial incentives with our 21st Century Care population health vision.

2) **What is not working well in the ACC Program?**

As detailed in the RFI, the ACC has "expanded focus from the medical home to the whole neighborhood of providers, such as specialists" and seeks in the new RFP to achieve "deeper integration, new payment reforms, and the promotion of whole-person/whole-family health" that considers the social determinants of health as well as medical care. This expanded vision is music to the ears of an integrated delivery system (IDS) that directly incorporates public health and variety of social services under its umbrella. DH believes that the current ACC one-size-fits-all, fee-for-service (FFS) provider payment model limits the ability to fully leverage both existing IDS's and any that would be newly developed under this expanded ACC scope. Additionally, DH has experienced certain challenges related to RCCO and BHO maps, delegated care coordination payments, attribution models, and timely data.

Payment Model: Specifically, the current ACC payment model has created misaligned financial incentives within Medicaid medical neighborhoods, incentivizing PCMPs (paid on value) differently than specialists and hospitals (paid on volume). Payment reform expert Harold Miller would locate the current ACC payment model (blended FFS and medical home fees) on the lower end of the payment continuum and well-suited for small practices and unrelated hospitals, which are common in Colorado. (See Exhibit 1 from Shih et al.)



Under this payment model, preventive service receipt and chronic care management should improve -- as they have in CO -- but savings may not be optimized without the active participation of other parts of the medical

neighborhood. For example, strategies to reduce potentially avoidable hospitalization are best achieved when the entire medical neighborhood and it partners are working collaboratively on this shared goal.

Miller argues (and the IDS literature confirms) that as "true" clinical integration increases – meaning integration at the level of clinical care, not mere contractual relationships -- the payment model must transition to more population-based payment methodologies to achieve maximum patient benefit and reduced costs.[vi] Furthermore, and relevant to ACC design considerations, Miller argues that moving from FFS to advanced payment models can be achieved incrementally, by matching payment models to variable delivery system readiness. A tailored payment approach would enable HCPF to benefit fully from advanced clinical integration and infrastructure where it already exists in systems and communities throughout Colorado. DH is aware of multiple organizations that are ready now for full or partial capitation, for example.

RCCO Maps: A second challenge of the current ACC program is that the current regional definitions of the RCCOs do not reflect current patient care seeking behavior nor provider practice and referral relationships and, as a result, many large PCMPs serve multiple RCCO regions. DH has currently enrolled RCCO patients from four RCCO regions, many of whom were previously established DH patients. This has meant redundant administrative requirements, reporting infrastructures, and conflicting priorities, adding complexity without any discernable patient value. Particularly challenging are very proscriptive requirements about specific care coordination processes (e.g., required use of specific tools) that do not consider established work flows that accomplish the same function. DH recommends holding RCCOs/PCMPs accountable to outcomes and functions (not specific processes) and revising RCCO boundaries to conform more closely to "natural referral networks", as recommended by original ACO architects, Fischer and McClellan. [vii] The latter is an especially important consideration as HCPF considers payment reform. A similar challenge exists with BHO maps, see questions #4-S.

Delegated Payments: The third major challenge with the current ACC model relates to the level and distribution of RCCO delegated care coordination payments. The institution of delegated payments recognized that RCCO-delivered practice transformation support needs vary widely especially between large and small PCMPs and, as such, is an important first step in tailoring payment models to delivery system sophistication. However, RCCOs retain an overhead of 33% or more in delegated care coordination contracts, and as a result, a large proportion of dollars meant for care coordination do not reach patients. We recommend that the state cap administrative fees for RCCO services to no more than 10%. This ensures that incentives are aligned with the care management process. We recommend that the state cap administrative fees for RCCO services to no more than 10%. This ensures that incentives are aligned with the care management process.

Attribution: A fourth major challenge relates to patient attribution. In some RCCOs, patients remain unattributed for long periods of time, up to several months. State PCMP attribution algorithms appropriately consider established patient/PCMP relationships as their foremost consideration. However, unattributed patients who do not have established relationship with a PCMP and who do not articulate a preference are not assigned in timely or transparent ways. In particular, no state guidelines exist for RCCOs to direct patients to high-performing systems, even though this has the potential to improve outcomes.

Finally, while the FFS SDAC data and dashboards have been very useful to analysis and performance monitoring, the timeliness of the data limits their utility for care coordination purposes. DH has near real-time access ED visits and hospitalizations that occur at our hospital, and we make this information available to providers and care coordinators at the point of care. It is part of DH standard work, for example, to prompt care coordinators to visit our highest risk adult patients while they are still hospitalized to assess their appropriateness for referral to our intensive outreach clinic (IOC). We have made similar information available through daily lists to RCCO Regions 2,3,5 for any of their members that visit the urgent care, emergency department (ED) or hospital at DH, so the RCCO may inform their non-DH PCMPs. We receive daily lists from our RCCO about our patients seen in Banner Hospitals and would like to receive similar near-real time information about DH RCCO members that are seen in all area hospitals or EDs. Lack of timely information is particularly problematic for the DH clinics located near the Denver County boundary, as their RCCO members are more likely than average to use non-DH hospitals and EDs.

In summary, to accelerate progress toward the population health transformation envisioned by HCPF, DH recommends that the next ACC RFP include an option for alternative payment models, including population-based payment models with gain-sharing provisions. Our response to individual questions in this RFI provides several related recommendations.

3) **What is working best in the Behavioral Health Organization (BHO) system right now?**

Due to funding limitations – Colorado ranks in the bottom half of state for mental health funding per capita[viii] -- BHOs primarily fund community mental health centers and cover specialized treatment of major mental disorders, especially for severe and persistent mental illness (SPMI), as well as related support services (i.e., case management, medication management, individual therapy, group therapy and skills-based classes, vocational services, etc.). Where the BHO system is working well is where there are strong partnerships at the clinical level, e.g., between PCMPs and community mental health centers. In Denver, DH and the Mental Health Center of Denver (MHCD) have a strong working relationship, and MHCD has been a key partner in co-managing the care of high-utilizing patients with severe and persistent mental illness who are treated in DH facilities.

In an attempt to address what the Denver Post has termed a "mental health crisis" in Colorado, some BHOs have been progressive in looking for opportunities to meet unmet demand for mental health services, especially for lower-acuity patients at-risk for their conditions worsening.[ix] For example, BHOs have begun to pay for "same day" behavioral health visits in primary care clinics, which is where most people receive their health care. Same day billing for behavioral health visits has allowed Denver Health to expand capacity to much better meet the mental health and behavioral needs of our patients. While same day billing is an important first step to financial alignment, further integration of funding is required. More integrated funding would continue to push towards whole person care rather than diagnosis-based and county-based care.

4) **What is not working well in the BHO system?**

As with RCCO regions, BHO regions do not always reflect patient care seeking or provider practice patterns. DH works with patients who are served by multiple BHOs. Alignment of RCCO/BHO definitions ("maps") that reflect clinical patterns on the ground is necessary for similar reasons as outlined in question #2. Substance abuse treatment services are also separately financed, which creates similar clinical integration challenges.

The onus is on patients with SPMI to schedule appointments in different systems and follow through, which is often very challenging given the nature of their conditions. Care delivery can be significantly compromised due to the complex delivery and financing arrangements.

Providers as well as patients are confused and frustrated with having care divided up in seemingly arbitrary ways across different systems that are subject to different rules. All of this is made worse if patients move during their treatment (which is common.) A DH patient experience is illustrative. An apartment fire caused a DH patient to temporarily move to another county. Although she had long-standing relationships with behavioral health providers at DH, she had to change mental health providers because she was no longer living in Denver. This change in providers was especially ill-timed given that she was in the midst of a personal crisis. She was (fortunately) able to continue her medical care at DH. However, it was difficult for the DH primary care provider to offer her "bridge" care while she got re-established in a new mental health system, due to the separate challenges associated with sharing patient health information across three sites of care. The financing system should not disrupt existing clinical relationships.

Additionally, the widely acknowledged under-financing of mental health and behavioral health services in Colorado relative to other states must be addressed.[x] It is important that all stakeholders recognize that long-term improvement will require expanding of provider capacity to meet the vast, unmet demand. This expansion will require collaboration from all stakeholders to ensure patient needs are met. Waitlists to enter care and the statewide shortage of mental health professionals are the predictable artifact of under-financing, as are the many recent, highly-publicized tragedies resulting from individuals with known mental health conditions whose families reported difficulty in finding adequate treatment for them.

5) **What is working well with RCCO and BHO collaboration right now?**

For the majority of DH RCCO/BHO patients, Colorado Access serves as both the RCCO and the BHO for a majority of our patients, which likely creates some administrative synergies that we are not well-positioned to comment on.

DH can speak more knowledgably about clinical collaborations between PCMP/BHO mental health providers. Under our CMS HCIA award (21st Century Care), DH formalized an on-going collaboration with the Mental Health Center of Denver (MHCD). MHCD is the largest community mental health center in the Rocky Mountain region and the nationally recognized leader in recovery focused services.[xi] Together, DH and MHCD care for more than three-quarters of Denver's Medicaid enrollees. MHCD has worked closely with DH in developing models for integrated behavioral health, and many of the new behavioral health consultants practicing in DH's primary care clinics were originally contracted from MHCD. Through the HCIA award, DH and MHCD have collaborated on implementing a High Intensity Team (HIT) that is based at MHCD and focuses on caring for patients with complex mental illness and high utilization of hospital services.

DH's primary care based behavioral health consultants provide support to primary care providers when behavioral health issues surface in the course of regular primary care. They refer patients as necessary to MHCD for more extensive follow-up. In addition, DH has implemented standard work to refer patients with significant mental health diagnoses and frequent hospitalizations to the MHCD-based HIT program.

6) **What is not working well with RCCO and BHO collaboration right now?**

As discussed in detail in question #2, BHO engagement and similar specialty network development efforts are limited under the current payment model. Even for many of the patients where the RCCO and BHO is the same, the underlying program design differences remain. Physical and mental health providers caring for the same patient cannot easily exchange medical records and test results nor can they readily collaborate on a coordinated medication management strategy. Duplication of laboratory and diagnostic testing is common. Voluntary efforts -- such as those undertaken at DH and described in #5 are no doubt taking place -- but many of the more care-disruptive and intractable issues relate to payment models. The most recent BHO contract required BHOs to promote integrated care but no new funding was provided to do so. As noted, some BHOs have begun to pay for same day integrated care services, there is much more that should be done but probably will not happen without additional funding.

Behavioral Health Integration

7) **What should be the next steps in behavioral health integration in Colorado?**[1]

Beyond payment models, the primary frontier for behavioral health integration relates to clinical implementation of evidence-based practices for the delivery of behavioral health services in primary care settings. However, the state can play an important role by assisting and facilitating capacity building, training, dissemination of best practices, and evaluation. Again, it will be important that these efforts are outcome-oriented and evidence-based. Primary care practices should be given some latitude to experiment with which evidence-based model works best with their population and practice model.

Capacity Building: As covered in previous questions, additional capacity and financing are needed to address Colorado's mental health crisis. Although adding behavioral health providers to the primary care team is a good first step, it does not necessarily lead to a change in outcomes alone. Other team members can play important supportive roles. For example, nurses/clinical pharmacists can help improve medication adherence and patient navigators/community health workers can assist with scheduling, transportation and increasing patients' engagement in care. Innovative uses of screening and low-cost automated tools (e.g., myStrength) are also warranted to identify patient education needs and to link patients to on-line or community resources.

Training: Focus should continue on increasing primary care-based behavioral health providers' knowledge, expertise, capacity as well as on understanding where primary care-based services fit within the entire care continuum. For behavioral health providers to be successful in fast-paced primary care environments with brief visits, they not only have to be trained to be comfortable in this setting, but they have to be supported in working in a more problem-focused manner, prioritizing brief intervention and therapy. Behavioral health concerns should be identified early, and there should be facilitation of communication, collaboration and treatment between providers. Ongoing encouragement for physical health providers to use the expertise of trained behavioral health specialists is warranted and will likely improve patient education and satisfaction. Reciprocally, primary care providers need training to become more skilled in addressing certain behavioral health concerns directly through, for example, training in motivational interviewing and behavior change. (A recent randomized study conducted at DH demonstrated that patients seen by PCPs who had received MI training had better depression outcomes at 36 weeks than patients seen by PCPs who had not received MI training.) Psychiatrists must be trained and supported to be able to help patients through a brief consultative model.

Dissemination: As noted, Denver Health has already committed significant resources to clinical integration and established strong collaborative relationships with the Mental Health Center of Denver (MHCD). We believe we have lessons learned and best practices to share from this experience. We would also like to benefit from the lessons learned from others that have implemented integrated behavioral health models. The SIM grant committee structure provides a great infrastructure for this dialogue.

Evaluation: There is a need to ensure that structured, evidenced based interventions are implemented along with systems to track outcomes. Evaluation of strategies around screening, patient engagement in treatment, medication adherence, and behavior change are key areas. Additionally, it continues to be important to

[1] Many terms and definitions can be found in the Appendix at the end of this document.

evaluate strategies for coordinating care for people with severe and complex psychosocial needs as well as severe and persistent mental illness and substance use.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Nearly all of the factors listed here are barriers to the clinical provision of care and have been covered in our previous answers.

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) **What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?**

DH believes the state should focus on functions and outcomes, rather than detailed requirements related to care models and process (e.g. requiring specific tools). With that caveat, we recommend that recognition for providing integrated care be based on a combination of factors. First, practices should score at least a level 4 on the Proposed Standard Framework for Levels of Integrated Healthcare scale. This means that there is close onsite collaboration between PCPs and Behavioral Health Clinicians and some system integration. It is important to recognize that this level of integration by itself will not guarantee improved health outcomes unless there are resources and protocols in place to manage common behavioral health problems.

Therefore, a second criterion should be that practices have established evidence-based protocols for common behavioral health conditions. However, these protocols should not be dictated by the state or RCCO. Qualified primary care practices (see above) should be given some latitude to experiment with which evidence-based protocols work best with their population and practice model, as there are numerous models and not clear evidence. The SIM grant presents a unique opportunity to test and evaluate alternate models, and the state should cast as wide as possible a net.

For example, DH has been working on implementing the evidence-based Collaborative Care Model for depression. The key components of this model are the following: patient education to inform and encourage patients to actively participate in decisions about their care, availability of brief evidence based therapies, ongoing monitoring of adherence to treatment with strategies to reengage patients who have stopped taking their medications or dropped out of therapy, ongoing monitoring of treatment outcomes with feedback reports of these results to both patients and providers, access to in-person and/or by phone or email consultations with psychiatry regarding medication management issues, coordinated protocol driven stepped care for patients who are not improving as expected. Other models exist and should also be explored.

Programs with these two broad features should be able to attend to the comprehensive needs of the patient including physical health, mental health, behavioral health, substance use disorders, and psychosocial issues with focus on both chronic disease management as well as prevention. Qualified programs should directly provide or have established referral relationships for specialty treatment, case management, disease management as well as health coaching for wellness/prevention and health behavior change counseling. Given the range of PCMPs that might seek to pursue this designation – large and small-- it may not be possible to require a common electronic health record with decision support, but that would be highly desirable. Similarly, access to telehealth services to reach patients who are unable to attend an appointment physically and/or to reduce other access to care barriers would also be desirable.

http://www.coloradomentalhealth.org/sites/all/themes/acmhc/2011%20Highlights.pdf

http://www.hpoe.org/Reports-HPOE/Behavioral%20health%20FINAL.pdf

10) **Please share any other general advice or suggestions you may have about behavioral health integration.**

Significant capacity-building for substance abuse treatment statewide will need to be undertaken to realize the full benefits of behavioral health integration.

Care Coordination

11) **Care coordination is an important part of the ACC Program.**

a. What is the best definition of care coordination?

While DH sees value in defining care coordination for the purposes of the ACC RFP, this is best understood as conceptual framework rather than a list of benefits. Specific care coordination models should not be dictated by the state or RCCO. Focus should be placed on broad care coordination functions and outcomes, not on allowed providers, required documentation, specific services or workflow processes. DH believes that there are a number of good definitions of care coordination developed by national organizations with content expertise that the state could use. A key feature of these definitions is consideration of service needs broader than just health care services. A few examples are listed below.

The Agency for HealthCare Research and Quality (AHRQ) define care coordination as "deliberately organized patient care activities and sharing information among all participants concerned with a patients care to achieve safe and more effective care' and offer examples of broad approaches (ie: include team work, care management, medication management, health information technology, PCMH) and activities (ie: communicating/sharing information, assessing patient needs and goals, creating a care plan, monitoring and follow up as needs change, linking to community resources, supporting self-management goals)."

The Safety Net Medical Home Initiative definition of care coordination is: "linking patients with community resources to facilitate referrals and respond to social service needs; integrate behavioral health and specialty care into care delivery through co-location or referral agreements; track and support patients when they obtain services outside the practice; follow-up with patients within a few days of emergency room visit or hospital discharge; and communicate test results and care plans to patients/families."

Lastly, the National Committee for Quality Assurance (NCQA) defines care coordination as "a function that facilitates information-sharing across providers, patients, types and levels of service, sites and time frames." It also provide tools to measure the implementation of care management in a practice (PCMH recognition).

b. How should RCCOs prioritize who receives care coordination first?

Care coordination should be given first to patients who are at the highest risk for poor health outcomes, those with complex conditions, and those with a history of potentially avoidable utilization.

c. How should RCCOs identify clients and families who need care coordination?

Within broad parameters (e.g., required focus on patients at risk for hospitalization), high-performing PCMPs should be able to tailor their operational definitions to existing identification methodologies and workflows. For example, DH uses a formal risk stratification ("tiering") process developed under

its CMS HCIA award (21st Century Care). RCCO members are stratified according to care needs into 4 risk groups for all adults and children. All patients who have used services at Denver Health are 'tiered' monthly and high-utilizers are identified daily. The primary building block of the tiers employs a predictive modeling tool/diagnosis group, a 3M product called Clinical Risk Groups (CRGs). CRGs are used for initial sorting of patients into the 4 risk tiers. CRGs consist of 9 mutually exclusive and clinically coherent groups (and corresponding subgroups) that are ranked according to financial risk. More specifically:

- CRG status 1 includes the set of individual CRGs that correspond to health individuals.
- CRG 2 includes those with acute issues only
- CRGs 3-7 are reserved for those with an increasing number and severity of chronic diseases
- CRG 8 corresponds to metastatic cancers, and
- CRG 9 is for catastrophic events, including trauma.

More than 90% of attributed patients are assigned to tiers based on their CRG. However, approximately 10% of patients are promoted to a higher tier due to concerning utilization patterns or children with special needs registry status. Unusually high utilization is often a marker for unmet social needs and/or behavioral health concerns.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

As recommended throughout this section, DH does not recommend a prescriptive approach to care coordination as such requirements are often pushed down to the PCMP, often without regard to the PCMP's system of care. Monitoring should focus on broad care coordination functions and outcomes, and any documentation requirements should be adapted to PCMP workflows not RCCO workflows. In an ideal world, RCCOs should have electronic communication interfaces with PCMPs so that recent utilization information and care plans can be easily shared and consolidated.

12) **What services should be coordinated and are there services that should not be a part of care coordination?**

No service should be explicitly excluded from care coordination. All healthcare and healthcare support services should be coordinated. This includes barriers to care and barrier resolutions—including such matters as housing, transportation, social service intervention (psychosocial, mental health), and transitional care. In order to provide a holistic, patient-centered care approach to care coordination, it would be necessary to assess and intervene in most all areas identified that prevent patients from receiving comprehensive care.

As such, it will be necessary for each PCMP to prioritize the care coordination services they feel will most benefit their patients and reduce unnecessary costs. Some common examples follow. Skilled Nursing Facility (SNF) and hospital to home transitions are likely to be a high priority for most PCMP's. Multiple hospitalization and/or ED visits, especially those with significant chronic conditions, also represent an

important opportunity for care coordination. DH has found that care coordination is especially important for patients who are leaving the criminal justice system and need to reestablish care in the community.

13) **What pieces of information are most important to have about someone in order to know what care coordination he or she needs?**

While it is efficient for RCCOs/PCMPs to use automated methods to identify potentially high-risk patients, self-reported information often remains the most effective way to identify patient-centered opportunities to coordinate care. Psychosocial information such as living situations, finances, education, behavioral health and substance abuse remain of utmost importance in determining how to coordinate services for an individual. This social/behavioral information along with access to health and medical information is essential to understanding all the issues necessary to identify actionable opportunities to mitigate risk for ED and hospital utilization. Some of the broad categories to consider are health behaviors, illness beliefs, social and functional needs, gaps in care and patient's preferences for addressing their possible needs.

PCMP (team) evaluation and care plan development should include a behavioral health and bio-psycho-social intake, patient/family goals, identified barriers to care with plans for barrier resolution, current/accurate contact information for the patient/family, best means of contact, and documentation of patient's readiness (activation) to participate in program. In many cases, it is the psychosocial issues that present the barriers to care and coordination.

14) **Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.**

a. **What care coordination is going on today?**

As described, within Denver Health, there is care coordination for RCCO members occurring in two main areas of the system – the divisions of managed care and ambulatory care services (ACS). Limited hospital based care coordination services also exist. Simplified, managed care offers centralized and typically telephone-based services, whereas ACS offers more face-to-face, primary care-based services, with additional telephone follow-up. As noted, the DH ACS and managed care staff often share information and resources to coordinate care for the most complex RCCO patients. Varying models of care coordination are employed and each area uses staff differently.

Within ACS, all patients are offered text message reminders about appointments and recommended preventive services. For lower risk patients, this low-touch support may be sufficient to support their good health. However, higher risk patients often need more frequent and/or more comprehensive follow-up care as well as substantial social/behavioral health support. 77% of DH Division of Medicine patients that readmit after discharge have a psychiatric or substance abuse history or both.[xii] Narrowly defined interventions have had little impact on utilization patterns for complex patients.[xiii]

DH expanded its primary care staffing model to include new team members to optimize clinical visits and support complex patients between visits. This enhanced care team includes patient navigators and clinical pharmacists for adults, pediatric nurse care coordinators, as well as social workers and behavioral health consultants. The staffing model varies by clinic type (pediatric, family medicine, and

general internal medicine) and patient population profile. Standard work has been defined for all team roles, and the primary point person for a patient is defined by patient need. Protocols exist at all clinics for outreaching to high risk/high cost patients for complex care coordination as well as following up with patients post-hospital discharge.

ACS also operates/funds three specialized clinics with small patient panels that focus exclusively on high-risk populations: CSHCN, medically complex adults, and adults with significant mental health diagnoses. All high-risk models provide tailored "wrap-around services" that focus on coordinating care for complex patients and addressing unmet social and behavioral needs. They also facilitate access to specialty care and community-based services ranging from development disability services, school-based services, substance abuse treatment, supported housing, supported employment, peer support, and residential treatment.

DH division of managed care provides centralized case management. Services range from a care support line for appointment scheduling or transportation needs, to telephonic health behavior coaching and counseling for patients with anxiety or depression, to chronic disease prevention and management programs, to complex case management programs. The latter programs offer intensive hospital discharge and other support services to high risk/high cost patients that are often provided in collaboration with primary care-based services that target the same population. Managed care staffing is similar to primary care staffing, consisting of patient navigators, health coaches, pharmacists and behavioral health counselors, but the central provision of services helps fill important gaps in primary care based services. For example, currently, only large ACS clinics have a dedicated clinical pharmacist. DH providers may refer RCCO patients to any of these programs and receive regular feedback reports on their patients. Managed care has also collaborated with the Denver Health Nurse Advice Line to develop centralized ED diversion strategies that include protocols to prescribe medications for many of the common problems that patients would otherwise result in an ED visit.

Finally, both ACS and managed care have implemented automated methods to identify and outreach to patients as well as to track care coordination activities. However, a true consolidated and shared electronic care plan awaits the completion of DH's transition to an EPIC electronic health record in 2015.

Additional detail on DH's centralized and primary care based programs is provided in question #1.

b. **What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?**

As described, DH collaborates with many different health and social services organizations on behalf of clients. Many of these organizations have their own case managers, all focusing on different aspects of managing care for an individual. The goal or purpose of intervening differs depending on the agency and the funding for intervention. Some programs use case managers to determine program eligibility and/or authorize services, so patients may not access services without their involvement. Although DH makes an effort to identify, especially for high-risk patients, any external case managers that can assist

with patient-centered care, care coordinators outside the RCCO or ACC may not be known and/or exchange information.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

It is important to recognize that care coordination is often accomplished by individuals with a variety of titles and training. Furthermore, similar titles, such as "case manager" or "care coordinator" often provide very different services, depending on organizational context. In exploring what is in place in a community, it important to look beyond titles and focus on function.

Furthermore, the patients of central ACC interest – the high-cost patients with high and potentially avoidable utilization -- often have many, many challenges that span medical, mental health, behavioral, and social domains. Patient "Hendricks" in Atul Gawande's famous New Yorker article is illustrative of the complex patient profile. (See below.)

THE HOTSPOTTERS

by Atul Gawande JANUARY 24, 2011

"Hendricks" had severe congestive heart failure, chronic asthma, uncontrolled diabetes, hypothyroidism, gout, and a history of smoking and alcohol abuse. He weighed five hundred and sixty pounds. In the previous three years, he had spent as much time in hospitals as out. ... A toxic combination of poor health, Johnnie Walker Red, and, it emerged, cocaine addiction had left him unreliably employed, uninsured, and living in a welfare motel. He had no consistent set of doctors, and almost no prospects for turning his situation around.

Like the Gawande-profiled program, DH has found that it is indeed possible to change the cost trajectory of even patients like Hendricks, but it often requires the concerted efforts of a multidisciplinary team of people – medical personnel, social workers, behavioral health consultants, clinical pharmacists, patient navigators, and others -- patching together a complex set of community resources from multiple organizations. A simple post-discharge phone call is not at all sufficient.

It may be possible to reduce some aspects of care coordination complexity by integrating the actual services, which has long been DH's philosophy as an integrated delivery system. However, even in our system that provides primary care, specialty care, behavioral health services, public health programs,

and certain social services as well as ED care, hospital care under a single administrative roof, we have found value in providing both primary care based and centralized service.

Given the inherent complexity of multidisciplinary teamwork, communication (early and often) is key both to good service and avoiding duplicated effort. It is important to discern who is doing what and why. It is often helpful to designate a 'primary' point of contact for the patient, which often works best if the patient selects this person. A consolidated care plan (electronic or otherwise) shared amongst all providers/payers is ideal, but often limited by privacy rules and lack of supportive systems.

d. What are the gaps in care coordination across the continuum of care?

Access to information on real-time patient care and cost information is an important gap that could be addressed in the forthcoming ACC RFP. Determining which patients would best benefit from care coordination remains a challenge and additional information to feed into PCMP risk profiling strategies can only help.

Additionally, in Denver, there are few programs that currently conduct home visits to assess patients within their environment. The literature has shown that home visits for high risk patients can be an important means to identify risk factors that might otherwise be missed and understanding the magnitude of needs that individuals may have. However, home visits are expensive and require qualified and highly trained staff and appropriate financing.

Also see 14 c about communication gaps due to the complexity of multidisciplinary team work.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs. Please complete the table below, keeping in mind adults, children, and families:**

The areas identified in the table below are functions that the organization providing care coordination should be providing, as they relate to a RCCO member's health.

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	

Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	
Health literacy	☐	☐	☐	
Housing	☐	☐	☐	
Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	
Transportation	☒	☐	☐	In particular for specialty visits.
Other				

16) **Requirements about who should be doing care coordination. Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:**

Care coordination models or care coordination titles should not be dictated by the state or RCCO. Focus should be placed on the outcomes desired, not on restricting or defining providers or provider teams. RCCOs and PCMPs with care coordination delegation should have flexibility to define a system that works for their population in achieving those outcomes. However, it is reasonable to require RCCOs/PCMPs to provide transparency in describing their care model as well as team composition, roles and responsibilities. Real care coordination is not achieved by titles, but by high functioning proactive teams dedicated to excellent care, working in systems with good tools. DH-specific examples are provided below.

Consistent with the above recommendation to focus on functions not titles, DH has distinguished the following titles as to whether they typically serve as care team leaders (primary care providers), provide advanced care coordination, or provide basic care coordination. We would be happy to share more detailed standard work specific to the DH implementation of these roles, upon request.

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	Part of DH's primary care based enhance care team, advanced coordination
Certified Addiction Councilors	☒	☐	Identifying resources, referrals
Certified Nurse Midwives	☐	☒	Function as primary care providers (may do some care coordination as well)
Community Health Workers	☒	☐	Basic coordination – transportation, appt scheduling and reminders, access to care
Generalists (BA/BS/MA/MS)	☒	☐	Advanced coordination (based on experience) – identifying needs and connecting to services/programs and resources
Health Coaches	☒	☐	Communicate with PCPs
Licensed Clinical Social Workers	☒	☐	Advance coordination including case management – ongoing assistance and follow up. Either providing or using other staff for basic coordination needs. Communicating with providers, coordinating all activities. Main/central point of contact for patients.
Licensed Marriage and Family Therapist	☐	☒	
Licensed Mental Health Counselors	☐	☒	
Licensed Professional Counselor	☐	☒	
Masters of Public Health	☒	☐	Advanced coordination (based on experience)
Medical Doctors / Doctors of Osteopathic Medicine	☐	☒	Function as primary care providers (may do some care coordination as well)
Nurse Practitioners	☐	☒	Function as primary care providers (may do some care coordination as well)

Patient Navigators	☒	☐	Basic coordination, more population management than individual management. More of a connector. Helps with logistics with guidance from clinical staff.
Peer Advocates	☒	☐	Basic coordination, more population management than individual management. More of a connector. Helps with logistics with guidance from clinical staff.
Promotoras	☒	☐	Basic coordination, more population management than individual management. More of a connector. Helps with logistics with guidance from clinical staff.
Psychiatrists	☐	☒	Communication with PCPs
Psychologists	☐	☒	Communication with PCPs
Registered Nurses	☒	☐	Advance coordination including case management (if their role included this). This would not include a direct practice nurse. Provides ongoing assistance and follow up for disease/clinical issues. May provide basic care coordination or use other non-clinical supports to assist. Communicate with providers, patient education, medication monitoring, coordinating all activities. Main/central point of contact for patients.
Social Workers	☒	☐	Advance coordination including case management – ongoing assistance and follow up. Either providing or using other staff for basic coordination needs. Communicating with providers, coordinating all activities. Main/central point of contact for patients.
Wraparound facilitators	☐	☐	
Other	Within a RCCO or PCMP with delegated care coordination, care team member roles and responsibilities should defined and communicated. Although there may be cross-over amongst roles, the team must communicate effectively to integrate care. The team must ensure that the physical, behavioral, long-term care, social and other services are continuous and comprehensive. All providers must communicate with one another to effectively coordinate care.		

17) **Care coordination requirements for specific populations**. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe

Newborns and infants	☐	☒	
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☐	☒	
Children involved in the foster care system	☒	☐	
Children with a chronic illness	☒	☐	
Children with a serious emotional disturbance	☒	☐	
Children with medical complexity	☒	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	
Transition-age adolescents	☐	☒	
Parents and families	☐	☒	
Pregnant women	☒	☐	Obvious risk groups – risk factors for low birth rate, adverse pregnancy outcomes
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☐	☒	
Adults with a chronic illness	☒	☐	
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	
Clients involved in the criminal justice system	☒	☐	When transitioning out of the correctional system, connecting to CBO's for resources and support
Clients with a disability	☒	☐	
Clients in a nursing facility	☒	☐	
Elderly clients	☐	☒	
Frail elderly clients	☒	☐	
Clients in palliative care	☐	☒	
Other populations, please comment:			

18) **How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?**

The RCCOs or PCMPs with delegation should be responsible for screening and the initial assessment and care plan. The RCCO can help facilitate access to these community based services and care coordination.

19) **How should care coordination be evaluated? How should its outcomes be measured?**

KPIs should continue to be used to evaluate ACC/RCCO outcomes. RCCOs and PCMPs with delegation will also need to establish productivity and other process measures. While these process measures should not be centrally defined, they could be shared. Larger PCMPs (e.g., those with delegation) may wish to establish additional measures for internal performance monitoring, including outcomes for specific populations (eg: children with special needs). DH has experimented, for example, with total cost of care, admissions for ambulatory care sensitive conditions, readmissions, ED visits for pediatric asthma, as well as patient satisfaction. The specific set of outcomes used will depend on the population being evaluated and should not be required.

20) **Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.**

a. **What is the PMPM cost for providing care coordination services?**

The current RCCO care coordination model relies on an infrastructure originally established for DH's managed care populations and greatly enhanced by a $20 million CM5 innovation grant. It is impossible to disentangle services that have been made available by virtue of the RCCO PMPM payments versus these previous and concurrent investments. However, given these prior investments, we believe the state is getting excellent value for its care coordination outlays in the form of downstream cost avoidance that we HAVE been able to quantify.

b. **Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?**

Yes, but only if the variation in PMPM is actuarially derived, ideally with some provision for known social risk factors (e.g., foster care status, immigration status, homelessness, etc.).

21) **Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?**

Since a variety of types of providers can perform different aspects of care coordination it not feasible to define a one-size-fits-all "care coordination to client ratio." RCCOs and PCMPs should have the flexibility to determine the type and number of staff needed to meet the needs of their population. Rather than focusing on staffing ratios, we believe it makes more sense to focus on functions and desired outcomes. However, RCCOs/PCMPs with delegation could be required to disclose the staffing ratios they have implemented along with a rationale of why this makes sense for their population and clinical practice setting.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐

51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) **How should care coordination outcomes be evaluated by the Department? Which metrics are most important?**

The Department should continue to utilize KPIs.

23) **Please share any other general advice or suggestions you have about care coordination in the ACC.**

Care coordination models should not be dictated by the state or RCCO. Focus should be placed on the outcomes desired, not on the allowed providers or provider team requirements.

Program Structure

24) **If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).**

This answer depends on if RCCO regions and functions remain largely the same as they are today: care coordination, practice transformation support, patient attribution and reporting, with no provider payment function. In this instance, it would be important to standardize RCCO care coordination delegation financing by capping administrative fees and to facilitate RCCO access to timely data.

However, HCPF's interest in moving toward advanced payment models has implications for RCCO design and functions that go well beyond these areas. DH recommends one of two options for implementing payment reform:

- **Permit multiple RCCOs per region with population-based payment**: allow one or more RCCOs -- defined by patient care seeking/provider practice patterns rather than patient residence -- to exist in regions, like Denver, *where doing so would enable more rapid achievement population health goals and population-based payment models*

- **Retain a single, regional RCCO with PCMP-level payment reform:** have HCPF retain its provider payment function (as today) and negotiate advanced payment models with IDSs and other PCMPs that are ready for them

DH recognizes the option one is a departure from how RCCO service areas are currently determined. Defining a RCCO's population according to patient *core preferences* rather their residence remains a population health-oriented approach, and arguably a more patient-centered one. Low-income populations are known to be mobile. In mapping its patient population, for example, DH has discovered that some patients are willing to travel long distances to access to DH services, especially Spanish-speaking patients and immigrants. Particularly in dense urban areas, regions defined by geography will result in arbitrary boundaries and resulting barriers to care and care provision at the patient-level.

Defining RCCO's by care seeking patterns is consistent with the ACOs envisioned by Fischer and McClellan and represents further consolidation of the RCCO and PCMP roles already begun under the current ACC model through delegated care coordination contracts. Merging RCCO/PCMP roles and functions in this way should be allowed *ONLY for delivery systems that can commit to partial- or full-capitation or similar population-based payments*. Regional RCCOs would likely continue to be needed to provide care coordination support to smaller PCMPs and nurture them along the payment reform continuum and possibly for patient attribution and regional planning purposes. This option address many of the concerns listed in #2 related to the FFS payment model, high administrative loads on delegated care coordination agreements, delayed attribution, and large PCMPs serving multiple RCCO regions.

The second option is for HCPF to retain a single, regional RCCO design and to work directly with integrated delivery systems and other larger PCMPs on advanced payment models. In this case, significant thought will still need to be devoted to redrawing RCCO boundaries to better observe patient care seeking and provider practice patterns. But, even if improved, any geographic definition of RCCOs is going to pose problems for patient care. Today, large PCMPs with delegated care coordination contracts with multiple RCCOs – DH works with two RCCOs in four regions -- face redundant administrative requirements, reporting infrastructures, and conflicting priorities. This places disproportionate burdens on the highest-performing parts of the ACC provider network. The state should cap at 10% overhead on delegated care coordination contracts and should also consider allowing PCMPs to elect (optionally) to affiliate with a single RCCO. Finally, the RFP should clearly articulate how a regional RCCO will provide value to all network participants, large and small alike.

DH does not recommend that RCCOs become regional payers without acknowledging this is a sweeping change to the RCCO role and function, effectively turning them into regional managed care plans, with different federal authority requirements, organizational and financial requirements, UM and billing data systems, and staff expertise. Not all current RCCOs meet these requirements. DH has successfully operated the only fully capitated Medicaid plan in the state for more than a decade. If the state wishes to transition the RCCO program to managed care model, DH is willing to share its experience and provide detailed thoughts and options.

25) **What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?**

RCCOs should be required to collaborate closely with local departments of public health on community needs assessments to share with PCMPs. It should have a demonstrated track record for improving the clinical collaboration between providers of different types and working effectively with a wide variety of community-based social, mental health, and housing programs and services.

26) **The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.**

Yes, see # 24.

27) **Should the RCCO region maps change? Why or why not? If so, how?**

Yes, they should reflect patient care patterns and provider practice patterns. Ideally, RCCO boundaries would be defined by patient care preferences not geography. Integrated delivery systems and other large PCMPs that are willing to commit to full- or partial-capitation should be allowed to form their own RCCOs. See #24.

28) **Should the BHO region maps change? Why or why not? If so, how?**

Yes, they match RCCO regions and both should reflect patient care patterns and provider practice patterns.

29) **Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?**

It would depend on the nature of the new RCCO role and the successful RCCO bidders.

30) **What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?**

The HealthColorado contract should better ensure efficient and accurate patient attribution as well as ensure retroactive payment to PCMPs. DH agrees with several of the technical suggestions offered by the CCHN response to the ACC RFI in this area. Additionally, special attention and outreach should be provided for recent immigrants who are more likely to encounter problems with current attribution methods.

Payment reform will also likely require state plan amendments (SPAs) or waivers to implement key program design features. Areas for regulatory investigation relate to upper payment limits, patient assignment provisions, and 12 months continuous eligibility requirements (to increase enrollment stability and reduce churn.) Suggested changes to the RCCO contract have been outlined in Question 24.

31) **What are the limitations of the current benefit structure and what – if any – changes are needed?**

The Medicaid adult dental benefit cap is too low. Substance abuse coverage and mental health financing is inadequate. Both contribute to a dearth of providers in these key areas.

32) **Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?**

Yes, in Denver. See #24 for a detailed rationale.

33) **If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?**

DH is a Medicaid provider.

34) **What role should RCCOs play in attributing clients to their respective PCMPs?**

RCCOs should be responsible for ensuring that everyone selects a PCMP within the first three months of enrollment. As enforcement of this responsibility, RCCOs could lose PMPM entirely for those that remain unattributed after three months.

35) **What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?**

The RCCOs should collaborate closely with CDPHE and local public health departments for regional planning purposes. See # 25. Also, the local health department should provide a letter of support to RCCO bidder.

36) **What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?**

The ACC and DHS should, at a minimum, compare goals to ensure alignment. This would be best accomplished at the Governor's Cabinet level.

37) **What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?**

The two programs should align eligibility determination methods and rules, including those related to income requirements and 12 months continuous eligibility. The latter is particularly important to reduce churning between Medicaid and the Exchange. Additionally, HCPF should provide real-time information to RCCOs/PCMPs, about members who will lose Medicaid eligibility at the end of the month due to excess income to reduce gaps in coverage and/or churn.

38) **What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?**

The ACC program should collaborate with DOI to ensure that the Medicaid definition of an Essential Community Provider is consider with the private insurance definition. This encourages consistent networks across public and private programs.

Stakeholder Engagement

39) **What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?**

The RCCOs should be required to form stakeholder workgroups consisting of advocates, state and local agency representatives, providers and other stakeholders. These workgroups can provide direction and feedback to the state regarding what does and does not work in existing programs. HCPF should require RCCOs to have consumer representation on its governance structure.

40) **What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?**

Workgroups should ideally meet at regular intervals and include representatives who can go back to their constituencies to relay meeting information and discuss solutions.

41) **Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?**

The location of the workgroups should occur in the various local communities being served by the ACC program. Consumer input will be especially valuable here.

42) **How should the Department structure stakeholder engagement for the ACC as a whole?**

HCPF should continue to host one or two regional stakeholder meetings per year. It is important for HCPF leadership and ACC staff to have a presence in each region at least once a year. Agendas and meeting materials should be posted at least two business days in advance of meetings. Agendas should clearly include opportunities for public input. Finally, HCPF must use technology that allows stakeholders outside of Denver, or those who cannot easily travel to meetings, to participate remotely.

Network Adequacy and Creating a Comprehensive System of Care

43) **Does the current network of PCMPs, specialist, behavioral health providers, hospitals, pharmacies, dental, home health and non-medical providers adequately serve the ACC population?**

   a. **If no, what are the gaps?**

   b. **Please address gaps for the population as a whole, and for specific subpopulations such ase children/families and individuals with disabilities.**

The Medicaid expansion has increased revenues for DH that we have been able to reinvest into expanded primary care, behavioral health, and specialist care access. Waiting lists are greatly reduced although persist in some areas, such as orthopedics and dental. DH has implemented an aggressive initiative to dramatically improve specialty care access in 2015 to project and meet the increased community demand, prompted by the coverage expansion.

44) **ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.**

   a. **What role should hospitals play in the next iteration of the ACC Program?** RCCOs/PCMPs should create a care transition system that includes specialists, hospitals, pharmacies, home health, hospice SEPs, CCBs, and PCMPs. Provisions for a shared care plan should be addressed. Additionally, hospitals should provide real-time admission/ED data to PCMPs and collaborate with them on strategies to avoid preventable utilization and to assess risk for readmission. This can be incentivized through the payment model.

      Specifically, DH has engaged with our affiliated hospital in the following areas/roles: transitions of care, reporting of recent ED visits, and proactive identification of patients for palliative/hospice care. DH is also investigating options for ED-based interventions to redirect care that does not require emergency room intervention. Active interventions are provided in the hospital for high-risk patients including patient education, case management, and assessment for intensive primary care services in our Intensive Outpatient Clinic (IOC). We would like to collaborate with other area hospitals in a similar fashion.

   b. **What role should pharmacies play in the next iteration of the ACC Program?** RCCOs/PCMPs should create a care transition system that includes specialists, hospitals, pharmacies, home health, hospice SEPs, CCBs, and PCMPs. Provisions for a shared care plan should be addressed.

      DH has found pharmacists to be key team members in both inpatient and outpatient settings. Medicine reconciliation is a common care gap and is often best addressed by a pharmacist. Pharmacists should be responsible for counseling patients who are receiving a first prescription for medication that they will need to take on a chronic basis and for enrolling patients in programs to

promote medication adherence such as refill reminder, late refill notification, and adherence/side effect monitoring.

c. **What role should specialists play in the next iteration of the ACC Program?** RCCOs/PCMPs should create a care transition system that includes specialists, hospitals, pharmacies, home health, hospice, SEPs, CCBs, and PCMPs. Provisions for a shared care plan should be addressed. Specialists can play a key role in treatment planning and patient education, especially for patients with poorly controlled chronic diseases.

d. **What role should home health play in the next iteration of the ACC Program?** RCCOs/PCMPs should create a care transition system that includes specialists, hospitals, pharmacies, home health, hospice SEPs, CCBs, and PCMPs. Provisions for a shared care plan should be addressed. DH believes home health agencies could be more active in conducting in-home post discharge assessments and working to develop strategies to reduce down-stream costs (e.g. readmissions).

e. **What role should hospice care play in the next iteration of the ACC Program?** RCCOs/PCMPs should create a care transition system that includes specialists, hospitals, pharmacies, home health, hospice, SEPs, CCBs,and PCMPs. Provisions for a shared care plan should be addressed. Palliative care programs are often underdeveloped, and providers may need additional training to identify appropriate patients for palliative and hospice care.

f. **What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?** RCCOs/PCMPs should create a care transition system that includes specialists, hospitals, pharmacies, home health, hospice, SEPs, CCBs, and PCMPs.

g. **What role should counties play in the next iteration of the ACC Program?** The integration of public health and primary care is important in terms of population health, disease prevention and health behavior change. Counties need to work with the health care system to address important social determinants of health such as housing and healthy food availability.

h. **What role should local public health agencies play in the next iteration of the ACC Program?** See #g (above) and #35.

i. **What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?**

This was covered in many of our previous responses. Collaboration with a wide array of community-based organization is critical.

45) **How can RCCOs help to support clients and families in making and keeping appointments?**

This is better handled at the PCMP-level as appointment practices vary. However, PCPMs could use no show rates to identify patients potentially in need of care management. DH triggers certain care coordination/care management activities if a patient is out-of-care for a defined period of time.

Most PCMPs, like DH, have appointment reminder protocols (phone calls, texting, letters, etc.) in place and often know those patients who have trouble keeping appointments.

RCCOs (or in DH's case, managed care "centralized services") could support PCMPs by communicating/collaborating with the primary care team—especially for those patients with known problems or barriers. Additionally, RCCOs can help ensuring adequate access to services so patients are able to receive needed care. If access is a problem (i.e. time to appointment is unacceptably long), RCCOs could advocate on behalf of the patient who may be reticent to complain directly to the clinic. RCCOs could also hold contracted transportation services more accountable for their performance (communications, on time pick -up and delivery, etc.) Finally, and importantly, RCCOs and PCMPs should empower patients to take a more active role in their health care, including how to make and keep appointments.

46) **Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?**

HCPF should not impose its staffing model preferences on RCCOs/PCMPs, but hold them accountable for functions and outcomes. One key function is that CHWs/PNs should be patient-centered not disease or condition focused. Disease focused navigation results in multiple navigators for complex patients that serves to replicate fragmentation rather than address it.

However, DH has found that patient navigators can play an important role in providing care coordination and/or helping patients navigate the system. In fact, we have successfully implemented PN in both our community health clinics and managed care/insurance settings. DH Navigators help patients by identifying transportation, scheduling, and other barriers to care and assisting patients/families with barrier resolutions. Access challenges and system complexity make PNs and CHWs important non-clinical team members for patients/families to be successful in their healthcare.

If we are referring to CHW and PN as lay persons, we must also ensure they are adequately trained to provide care coordination and help patients navigate complicated systems while understanding their limitations and when/why to use clinically trained colleagues for needs involving that level of intervention. While there is training offered through the University of Colorado, there are no accepted standards that validate an individual's training, qualifications or experience to be a 'patient navigator' in Colorado (although this is in the works).

47) **Community Health Worker reimbursement**. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☒
On staff (salary) at RCCO	☒
Per Member Per Month Payment	☒

48) **Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?** RCCOs should coordinate dental services as part of the overall healthcare for a patient. However, the current problem is less a coordination issue than an access one due to low/no reimbursement rates. It may be difficult for the RCCOs to address this issue without addressing the reimbursement for this service.

49) **Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.**

a. **What does cultural competence mean to you?**

The National Committee for Quality Assurance defines cultural competency as not only having empathy, but expressing it towards patients regardless of the patient or provider's culture background. In order to do so, clinical and non-clinical staff must have an adequate understanding of the patient population including its diverse health literacy, language and cultural needs. In practice, cultural competence is about 'asking the right question' which might include asking questions like what is your understanding of your illness?, what does this illness mean to you?, what are your concerns about it?, what are your goals?, are there any specific things you would like me to do to help you with this problem today? It requires understanding health conditions from the patient's perspective. Cultural competence is a set of congruent behaviors, attitudes and policies that come together in a system or amongst professionals and enable that system or team to work effectively in cross-cultural situations. It is a developmental process that evolves over time.

b. **What RCCO requirements would ensure cultural competency?**

All clinical staff should be trained in cultural competence with periodic follow-up to ensure providers have the skills to evaluate patient's perception of illness including their concerns, goals and preferences. Ideally, providers could then modify/alter/consider different approaches or recommendations with patient preferences and perceptions in mind. RCCOS should require that

providers/organizations have policies and procedures in place that: value diversity, have capacity for cultural self-assessment, are conscious of dynamics inherent when cultures interact, have institutionalized cultural knowledge, and have developed adaptations to service delivery reflecting an understanding of cultural diversity. Availability of interpreting and translation services is also critical. RCCOs could assist in developing patient education materials for use in some of the more common language and cultural groups.

c. **What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?**

RCCOs should ensure providers and practices have access to interpreting and translation services and materials that reflect the population served to ensure patients are communicated with in their preferred language. For example, the vast majority of DH PCMP-based providers are bilingual English and Spanish speakers and all have access to the "language line" to provide translation services by phone in any language. As well, DH requires that written communication be at literacy level that is reflective of the population they serve (ie: 6th grade for Medicare).

d. **Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?**

The SDAC and practices should be encouraged to analyze key outcome data to determine if there are any ethnic or racial disparities among RCCO populations for specific focus. RCCOs should provide support for developing QI interventions to address any identified disparities. RCCOs could require providers and organizations to have the skills, policies and system components outlined in b and c above.

50) **Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?**

In the context of health plan network design, well-designed preferred networks that focus on high performing providers have been shown to provide comparable quality at a better price as compared to broad networks. However, without significant movement along the payment reform continuum, RCCOs will not have the ability to develop or enforce such networks.

51) **Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?**

A multi-pronged strategy that focuses on payment as well as patient and provider behavior is required to reduce ED rates. DH believes the State should examine how payment reform can align financial incentives with more appropriate ED use, especially for use related to non-emergent conditions. Additionally, patients need education and real-time support in determining when to use the emergency room as well as alternative home-based strategies, for example, around the home management of common ambulatory problems such as upper respiratory infections, cough, abdominal pain, especially in children.

Provider-level solutions should focus on alternatives to ED use in the evenings and the weekend, such as DH's nurse advice lines, telephonic and/or email communication with physicians, and after hours care. Phone or email protocols to manage common ambulatory conditions that frequently result in ED use should be available. Post-ED follow up for patients seen in the ED for high-risk conditions should be provided. ACC must work with providers and emergency departments to coordinate care in real-time to facilitate transition of patient/family to most appropriate place of care.

Longer-term solutions require re-examining care delivery models. For example, DH has co-located its urgent care and emergency services, triaging patients as they arrive. It also created a 100-bed alcohol detox unit (Denver Cares) to divert inebriated, but otherwise healthy, patients from the ED. Given that many area hospitals advertise their ED wait times, payment model changes may be required to incentivize these types of care delivery innovations.

52) **Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.**

During 2014, the process of getting a primary care appointment has been dramatically improved at Denver Health. Since the economic challenges of 2008, known as the Great Recession, existing primary care capacity was exceeded and a waitlist was created to provide an orderly waiting process and to use the data to improve performance. The waitlist peaked at just over 10,000 in October 2013 and by November of 2014 the backlog was eliminated and the waitlist is now zero. The delay from time of request of appointment to providing the appointment is reduced to under 30 days, similar to private sector wait times to appointment for new patients.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Specific tools should not be required.

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☒	☐	☐	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☒	☐	☐	☐
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☒	☐	☐	☐
Supply behavioral health surveys	☒	☐	☐	☐
Supply other self-screening tools	☒	☐	☐	☐
Administer behavioral health surveys	☒	☐	☐	☐
Administer other self-screening tools	☒	☐	☐	☐
Prepare client action plans	☒	☐	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☒	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☐
Provide referral and transitions of care checklists	☒	☐	☐	☐
Provide visit agendas or templates	☒	☐	☐	☐
Provide standing pharmacy order templates	☒	☐	☐	☐
Provide comprehensive directory of community resources	☒	☐	☐	☐
Provide directory of other resources	☒	☐	☐	☐
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐

Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others				

54) **If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.**

No specific tool should be required. PCMPs should select tools that meet ACC program goals and outcomes and work well within their system and work flows.

55) **What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?**

RCCOs should provide resources and support as requested by practices, but they should not be prescriptive For example, formal practice coaching such as that provided by Health Teamworks should be made available to practices that desire this type of support.

56) **What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?**

Practices should receive additional PMPM reimbursement based on their level of NCQA certification and meeting CMS requirements for Health Homes. Under population based payment models, down-stream cost avoidance should be reinvested in comprehensive primary care programs.

57) **Should the Department require that PCMPs utilize disease registries to manage the health of their population?**

All PCMPs should utilize a registry or electronic health record to produce population health management reports for care coordination purposes. For example, DH generates daily care coordinator worklists of people recently discharged from the hospital or visiting the ED as well as a variety of preventive service reminder lists and "gaps in care" lists for individuals with chronic conditions. Supplemental data provided by the SDAC may also be useful, if it is timely.

58) **Please share any other advice or suggestions about provider support in the ACC.**

The RCCOs should provide the basic infrastructure, as needed, that would enable PCMPs to perform and evaluate meaningful QI interventions.

Payment Structure and Quality Monitoring

59) **Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?**

The stated goals of the ACC include providing the Colorado Medicaid program with a client and family centered, whole person approach that improves health outcomes and ensures savings, with a focus on clinically effective and cost-effective utilization of services while identifying and using local resources to meet client needs.

While the current structure has shown some positive results with respect to quality and cost effective utilization of services, our view is that the current payment structure does not maximize savings because of payment to providers remains a fee-for-service reimbursement. It also discourages specialists and hospitals from being active participants in a population health model that threatens their financial viability under current business models. We recommend a movement toward capitation or other population-based reimbursement, at least for primary care services, and at least in regions where there are providers or RCCOs who are prepared for such a migration. Risk corridors or other variations on shared savings should be considered in order to encourage participation.

DH has made significant investments in population health tools (like EPIC and patient text messaging) and care models (like 21st Century Care) to help us migrate fully from a medical model to an outpatient-oriented, patient-centered, population health model. We worry that if the payment model does not align in time, we will lose ground and achieving our shared population health vision for Denver will be set back a number of years.

60) **If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?**

Yes, DH would be open to capitation payments rather than fee-for-service. Ideally all three elements of integrated, whole person care (physicial, behavioral and oral) health would be included. DH provides a broad range of services through its FQHC clinics. As an initial step toward full capitation, we envision that the FQHC-related primary care services could be included in a primary care capitation, including physician services, non-E&M PCMP services, and OP Labs/Pathology as these are services handled by PCMPs. In later years, the program could expand to cover additional services such as diagnostic imaging, PT/OT/SP, certain DME, and OP Radiology (professional services). Assuming upper payment limit (UPL) issues could be resolved to mutual satisfaction, an even broader set of DH medical neighborhood services could be provided, inclusive of hospital services.

61) **Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?**

No, many of them do not, and some small rural providers may never have this capacity. However, many larger providers, such as DH, do have capacity, and as argued in question #2, we believe the payment model should be matched to provider readiness for advanced payment. In general, value-based payments are best handled by providers with a large patient population, that offer a broad array of services, with an evidenced-based staffing model (e.g., PCMH, integrated behavioral health care, team-based care coordination), and IT resources for population health activities such as monitoring health needs, identifying high risk patients, and assessing performance. The major barriers are provider size and access to capital/reserves. The following is a list of characteristics that we believe demonstrate DH's readiness for payment reform and could be similarly used to assess whether other providers have the requisite infrastructure.

DHHA("the Authority") operates an HMO which is a separate S01(c) 4 corporation but a wholly owned subsidiary of the Authority, Denver Health Medical Plan (DHMP). Under a direct contract with HCPF, DHHA has also operated the state's only fully capitated Medicaid managed care plan (Medicaid Choice) for more than a decade, producing higher quality for members than FFS programs on most HEDIS quality metrics and at a lower price.

In addition to its experience with capitation, DH has or is developing infrastructure to effectively operate under other forms of value-based payment. As discussed, our integrated system provides a solid foundation for this payment model as we control nearly the full continuum of care, including primary care, specialty care, behavioral health, ED/urgent care/inpatient services, a 24-hour nurse line, Denver's 911 system, and even public health services. We offer both centralized and primary care-based care coordination services with focused initiatives for high-risk patients. In 201S, we will upgrade our electronic health record to the EPIC system. A highly functional electronic health record (EHR) is essential for future success under value based payment, and EPIC is the EHR of choice for nearly every other large hospital based system in Denver and nationally.

Historically, a barrier to success under value-based payment has been ensuring adequate access to DH's primary and specialty care. The issue of access to specialty care for Medicaid and underserved populations is not unique to DH. However, with Medicaid expansion revenues, DH has made significant progress toward matching primary care access with community demand, with near-elimination of the waitlist for appointments. DH is undertaking a similar effort in 201S to improve specialty care access. However, DH projects that an expanded network of contracted providers would be needed in order to adequately provide access to specialty care. DH believes it could play an important role in increasing the overall level of specialty care services to Medicaid members under a value-based payment model.

62) **The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?**

DHHA ("the Authority") operates an HMO that is a separate S01(c) 4 corporation but a wholly owned subsidiary of the Authority, Denver Health Medical Plan (DHMP). This entity is licensed by the DOI. DH also operates DH Medicaid Choice, a risk-based capitated plan under the Authority's direct contract with the State

Health Care Policy and Financing agency; this plan is not licensed by the DOI but maintains all necessary reserve requirements as if it were and these reserves are recommended and approved by outside actuaries and determined by be adequate by our independent auditors. The requirement regarding an HMO license would not preclude DH from bidding as if this were a requirement it would be handled through the DHMP. However, as we have demonstrated success in managing reserves through DH Medicaid Choice, and since DHMP provides care management and claims payment services to the Authority under an operating agreement, we effectively meet all DOI requirements. We would prefer the flexibility to operate as a RCCO through the Authority. This too is consistent with an ACO model in which providers receive direct payment.

63) **What role – if any – should the RCCOs play in the distribution of payments to providers?**

As discussed in question # 24, payments should be distributed directly to PCMPs (or RCCOs that are redefined as delivery systems.) Additional layers of administrative entities generally dilute/reduce the dollars directly allocated to the provision of health care services. There is not value added by having the RCCO act as a third party for payment purposes, and it adds complexity.

64) **Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.**

As discussed in question #24, we recommend that HCPF consider more than one RCCO in Denver County. Given the large population in metro Denver area, the large number of Medicaid users that access DH, DH's unique population health-oriented, integrated delivery system, and DH's readiness for an alternate payment model, a DH-specific RCCO could be dedicated to the DH population. This would eliminate unnecessary administrative overhead and duplication of effort that occurs under the current system, freeing up additional dollars for patient care. Using patient preference to define RCCO regions (rather than geography) is consistent with the literature and potentially extensible to a handful of other, high performing PCMPs.

We also applaud and encourage the State's efforts to combine physical and mental health under a single reimbursement structure to promote whole person care.

Under any scenario, rates paid to providers need to be adequate to reimburse the legitimately demonstrated cost of care provided, in order to maintain provider participation, support essential community providers, and ensure choice for patients. In order to encourage cost efficiency, shared savings models and risk corridors should be continued/developed. A model that capitates primary care, incorporating behavioral health, is a good start toward moving to the next level of payment reform in the ACC program. Structuring the payment model in this way also preserves the Upper Payment Limit (UPL) reimbursements on which many hospitals, including DH, are dependent in order to continue to cover the cost of the remaining uninsured population. At DH, the percentage of patients who are uninsured is still 13% which approximately 3 times the average for Colorado hospitals. Provider subsidy supports for hospitals for serving the uninsured will begin phasing out in 2016, so the window of opportunity to change the payment model is closing.

65) **What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?**

Measures should align with managed care HEDIS and CAHPS measure and/or already established PCMP metrics, to reduce PCMP/RCCO data burden. RCCO performance may be benchmarked to managed care performance.

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and 5ystems (CAHP5)	☒	☐	In 2012, CCHN worked with its members, including DH, to establish patient satisfaction measures that would meet the NCQA PCMH requirements. The full CAHPS survey is composed of 52 questions and the administration of it in entirety was felt to be too administratively difficult to implement. CHCs did agree to utilize and report on 5 questions from CAHP5, and we would advocate considering this shortened version to evaluate patient satisfaction: 1. In the last 12 months, how many days did you usually have to wait for an appointment when you needed care right away? (a. Same day, b. 1 day, c. 2 to 3 days, d. 4 to 7 days, e. More than 7 days) 2. In the last 12 months, how often did this provider explain things in a way that was easy to understand? (a. Never, b. Sometimes, c. Usually, d. Always) 3. In the last 12 months, did anyone in this provider's office talk with you about specific goals for your health? (a. Yes, b. No) 4. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 12 months, did you see a specialist for a particular health problem? (a. Yes, b. No – if no, skip question 5) 5. In the last 12 months, how often did your provider seem informed and up-to-date about the care you got from specialists? (a. Never, b. Sometimes, c. Usually, d. Always)
5F-12 Health Survey	☒	☐	This tool is not used by DH at this time, so while we have no objection to it being an option, it should not be the only tool available.
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☐	☒	The tool is not used for assessing patient engagement. DH's managed care department has not found it to be predictive of readmissions.

Focus groups	☒	☐
Other	The state should focus on patient satisfaction tools, not patient education tools. Additionally, as referenced in other questions, tools should not be prescriptive and requiring practices to implement duplicative efforts.	

67) **Knowing that, at this time, the Department only has claims data, how should population health be measured?**
HCPF should look beyond claims data to other partnerships that could be provided to develop data on population health, in particular through partnership with the Department of Public Health and Environment. Claims data, lab and pharmacy data, CDPHE's health survey data, and outside data sources such as the Colorado Health Access Survey could be utilized to measure population health until more robust and timely data tracking and measurement tools are in place. Sample size will be a known limitation here. In developing ways to measure population health the Department should not develop prescriptive tools for implementation in PCMPs, but should look for ways to mine data from what is already tracked by PCMPs.

Aligning performance metrics with managed care and or FQHC UDS performance metrics, some of which are claims based, would allow HCPF to compare RCCO performance to managed care performance for similar populations in Denver.

68) **How should quality and performance data be reported to the RCCOs, PCMPs, and the public?**

PCMPs should be included in the development of reporting models in order to ensure transparency in how their data is utilized and that reports are presented in a way that can be utilized to facilitate further improvements in their system. To address these concerns, a review system should be established to create and maintain transparency and integrity of data, and large PCMP systems, such as DH and other FQHCs, should have representation in that system.

Quality and performance data should be reported to PCMPs consistently across RCCOs so that those who serve patients across multiple regions can better understand their impact on their patient population. Additionally, this data should be provided on a regular basis and should include comparison information demonstrating not only how the PCMP is performing in relation to itself, but also in relation to comparable practices and the region as a whole. Presenting comparison data is the only way to know who the top performers are and identify ways to learn from their system to achieve the triple aim.

Aligning performance metrics with managed care performance metrics allows the additional comparison in Denver across delivery system design/payment models.

69) **Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.**

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

HCPF has had a tendency to change measures frequently. Impact cannot be measured over time if the measures do not remain consistent. Over time it would be feasible to add additional measures, but it would be preferable to identify a set of core measures that will be maintained.

70) **What percent of RCCO payments should be tied to measures or performance?**

Percentage	
10-20%	☒
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

The percentage should start low and perhaps increase over the period of the contract as policies and reporting systems need to be established in order to tie payment to performance. As noted, DH is interested in the development of models with capitation and risk corridors, but in developing those models we are opposed to a fixed formula regarding the percentage of payment tied to performance. The question should be regarding how to accelerate payment to high performing PCMPs

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Yes, all regions should have the same KPIs, and RCCOs and providers should be working toward the same statewide goals. This is necessary because to achieve KPI performance, large PCMP systems, such as DH, must adopt organization-wide quality initiatives which will impact patients across multiple RCCO regions (under the current, regional RCCO model.)

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Reimbursement should be based on progress toward meeting national quality standards, with ongoing rewards for those who meet or beat the standards. While it might be necessary to create incentives that are based on individual improvement to encourage movement towards national standards, payment systems should more heavily reward those that have met and continue to beat national standards for comparable patient populations. Risk adjustment is critical here.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

Yes

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

However, incentive payment frequency may depend on the measures we are being incented for but whenever possible quarterly would be ideal.

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

Increased transparency, as discussed in several questions, is necessary to strengthen PCMP relationships with RCCOs as it is not clear that funding is being sufficiently invested in care and the care system. To address this, RCCOs should have a ten percent administrative cost threshold. Additionally, a medical loss ratio standard should be established and RCCOs should have reporting requirements regarding funds spent and unspent.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

The primary care delivery system portion of DH is an FQHC (CHC). CHCs monitor and report performance publicly via the Uniform Data System and small amounts of funding are increasingly tied to quality payments, including:

- Performance in Medicare Advantage
- Meaningful Use has paid practices based on meeting quality outcomes with HIT PCMH attainment

CHCs are increasingly seeking and occasionally receiving reimbursement for performance on patient satisfaction, provider satisfaction, services and screening rates, and access and availability measures.

Additionally, DH produces HEDIS data for its Medicaid Choice members.

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☒
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☒
Smartphone app	☐	☒
Other: Under its CMS HCIA grant, DH has innovated in the area of electronic communication with patient, especially via text messaging.		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☒	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☒	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☒
Patient education/wellness tools	☒	☐

Provider/case manager directory	☒	☐
Shared decision-making tools	☒	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☒	☐
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☒	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☒	☐	☐
Health risk assessment software	☐	☐	☒	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☒	☐
Patient education wellness tools	☐	☐	☐	☒	☐
Provider/case manager directory	☐	☐	☒	☐	☐
Shared decision-making tools	☐	☐	☐	☒	☐
Telemedicine	☒	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

80) **What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?**

Cost and patient access to the technology (ie: computers and smart phones), PHI concerns, having a data base that has patient email addresses and phone numbers.

81) How can Health Information Technology support Behavioral Health Integration?

DH managed care is currently using My Strength to support behavioral health integration; an online emotional wellbeing website. Both primary care providers and behavioral health providers can offer My Strength to their patients. We are integrating specific videos from My Strength into our telephonic counseling program for depression and anxiety.

We have also developed an effective telephonic counseling program for patients with anxiety and/or depression. This program consists of a comprehensive psychiatric assessment followed by up to 10 therapy sessions. Patients may select the types of therapies they feel will be most helpful for them from a menu of 14 different therapy modules. These telephonic therapy sessions are supplemented with technology facilitated between visit outreach communications in which patients may view related videos from the MyStrength website, hear stories from other patients who have successfully completed the program and report on their medication adherence, mood and progress in completing their homework assignments. After completing the program patients are asked at regular intervals to complete a PHQ9 and those whose scores have begun to increase are offered the opportunity to reenroll in the program for booster sessions. Participating PCPs receive regular reports on their patients PHQ9 scores the therapy modules they have worked on and protocol driven recommendations on how to adjust antidepressant medications and reinforce the skills learned in therapy.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

Yes. Key requirements include clear and detailed data dictionary defining the data sources and measure definition (at the level of pseudo computer code) for all variable metrics. Transparency can be further established by ensuring the ability to see raw data being compiled and a vendor that is responsive to questions.

The analytical platform should operate as a data cube, enabling power users to manipulate and download data. With appropriate permissions, a RCCO/PCMP should be able to access identified data to permit person-level analyses that link RCCO data to other provider data. In addition, canned reports should be available that address overall program goals and permit performance benchmarking.

Care coordinators need real-time data.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

While it would be ideal for there to be a care management tool that was shared by the RCCO and its affiliated PCMPs, it should not be required. The tool would be more likely to be adopted by PCMPs if it was easily integrated into the practice workflows and electronic health record and contained the following

functionality: easy ability to load scripting tools and assessments, care planning and goal setting, outcome tracking, report generation, and to be able to upload claims data, pharmacy data as well as clinical data, identify gaps and care assessment.

84) **Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.**

Again, these should be PCMP specific, not RCCO or ACC imposed. DH has found that it is very useful to have electronic communication tools to engage the RCCOs population and has experimented with text messaging, email, and IVR technology. Both the RCCO and its affiliated practices should be able to use a variety of tools to outreach to populations of patients for specific types of activities. The population health tools should be able to capture data in a PHI compliant environment and provide dashboard reports and alerts to the appropriate providers.

85) **Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.**

Provide easy look-up of providers by specialty and geographic location. The provider directory should be searchable by provider, specialty, site, and/or entity; contain information about if they are accepting new enrollees; and contain accessibility information such as hours of operation and languages spoken. If HCFP adopts our recommendation to attribute patients preferentially to high performing health systems, this status should also be noted. Brief descriptions of specialized services provided would also be useful.

The provider interface should have a way to easily update information, contain provider contact information, and contain information regarding making referrals to the practice.

86) **How can the RCCOs support providers' access to actionable and timely clinical data?**

RCCO should facilitate PCMP access to actionable, real-time data by working collaboratively with providers, hospitals, specialists and PCMPs. A change in payment models would accelerate this work, as sharing this information is currently voluntary, technically complex to implement, and potentially not in the current financial interests of fee-for-service providers.

RCCOs could also be supportive of efforts to join CORHIO. RCCOs could also check in regularly with PCMPS re: their satisfaction with the referral and communication process within their specialty networks. Opportunities for improvement should be identified and addressed.

87) **What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.**

There are many HIT solutions that would provide benefits to clients, providers, and RCCOs, including web portals, text messaging, interactive videos and telemedicine.

DH has successfully used text messaging to remind patients of appointments, with a demonstrated reductionin no show rates. Text messaging has both been used push out information to patients as well as to capture important information from the patient. Additionally, DH has experience with telemedicine (for

rural access to specialty consultation) and interactive videos. These latter two technologies are helpful to reducing barriers associated with long travel distances and low health literacy.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

RCCOs could contract with communication technology vendors and provide assistance to PCMPs on how to use the services provided through the vendors.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

RCCOs should encourage participation in CORHIO to ensure the flow of meaningful information in standardize formats between organizations.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

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[i] Gabow P, Eisert S, Wright R. Denver Health: a model for the integration of a public hospital and community health centers. *Ann Intern Med.* Jan 21 2003;138(2):143-149.

[ii] Meyer H. Life in the "Lean" Lane: Performance Improvement at Denver Health. Health Affairs. 2010;29(11): 20S4-2060.

[iii] Neal Halfon M.D., M.P.H, Director, UCLA Center for Healthier Children, Families & Communities, nhalfon@ucla.edu as cited in CMS Center of Innovation,

[iv] McClellan M et al. A National Strategy to Put Accountable Care Into Practice. Health Affairs. May 2010. 29(S):982-990.

[v] Nuzum R et al. Denver Health A High Performance Health Care System. The Commonwealth Fund. 7/12/ 2007.

[vi] http://www.pcpcc.org/sites/default/files/resources/Effects%20of%20Integrated%20Delivery%20System%20on%20Cost%20and%20Quality.pdf

[vii] Fischer ES, McClellan MB et al. Fostering Accountable Health Care. Health Affairs. 2009;28(2):219-231

[viii] http://extras.denverpost.com/mentalillness/ Denver Post 11/23/14.

[ix] http://extras.denverpost.com/mentalillness/ Denver Post 11/23/14.

[x] http://extras.denverpost.com/mentalillness/ Denver Post 11/23/14.

[xi] MHCD awards include: The 2011 Excellence in Service Innovation Award from the National Council for Community Behavioral Healthcare; The 2010 Science and Service Award from the Substance Abuse and Mental Health Services Administration (SAMHSA); The 2009 Science to Service Award from the Substance Abuse and Mental Health Services Administration (SAMHSA); The 200S Community Provider of Excellence Award from the National Council for Community Behavioral Healthcare.

[xii] Based on a DH analysis of adult Medicine discharges from inpatient care between January 200S and December 2009, 77% of readmissions (within 30 days) had a history of a psychiatric illness and/or substance abuse.

[xiii] Liptak GS et al. Effects of Providing Comprehensive Ambulatory Services to Children with Chronic Conditions. Arch Pediatr Adolesc Med. 1998;1S2:1003-1008.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 110

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Michelle Trujillo
Location: Grand Junction, Mesa, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Mesa County Department of Human Services
Location: Grand Junction, Mesa, Colorado
XX Please check if you are answering on behalf of this entity

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Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
XX Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☐ Yes
XX No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Recipient of data- high level demographics related to ACC participation

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Local Administration of Medicaid Eligibility Determination- Mesa County

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
XX N/A

Please feel welcome to describe why or why not using the space below.

☐ 3-4 years
☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

2) What is not working well in the ACC Program?

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Connection with local departments of human services, as well as other community providers of services that assist individuals with meeting basic needs, in addition to medical services. A full assessment of the laws and rules governing sharing information between behavioral health providers and other service providers to assure protection of confidentiality and allow for better case management.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	XX	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/

Care coordination in the primary care practice involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.

This means that the patient's needs and preferences are known and communicated at the right time to the right people, and that this information is used to guide the delivery of safe, appropriate, and effective care.

Timely communication is important. Coordination and communication takes work, but many times a client's health condition requires expedient communication and coordination, so emphasizing timeliness is important.

b. How should RCCOs prioritize who receives care coordination first?

Through Medicaid reports, if it is possible to see customers who are accessing medical services through multiple care providers with a regular frequency over a certain period of time, these might be the best folks to start with.

A person who only sees a provider once a year may not need to be a high priority.

We encourage priority attention to clients receiving crisis or other high-level behavioral health services.

c. How should RCCOs identify clients and families who need care coordination?

Same as above.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

Using an electronic tracking system would be ideal. I imagine shared information systems for medical providers like QHN locally are helpful.

12) What services should be coordinated and are there services that should not be a part of care coordination? Connecting potentially eligible people to basic needs resources like Food Assistance/SNAP and shelter/housing, in addition to Medicaid, is valuable. Whether or not basic needs are met contributes to an individual's overall health. Second, coordination with behavioral health providers is very important.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs? Health history, history of medical providers seen where records may exist, current assessment of medical needs. Also, history of behavioral health diagnoses and treatments/medications.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

    a. What care coordination is going on today?

    Depending on the client, various case management functions in the Human Services arena provide assistance to clients to coordinate care. This happens primarily in the Single Entry Point (Options for Long Term Care) and Adult Protection areas, where case managers work with elderly individuals and/or individuals with disabilities. In rare cases, a human services agency/county will act as guardian for an individual.

    b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

    Routine care coordination can occur at the case manager level, with some communication with the RCCO. In complex and/or crisis situations, the RCCO is at the table.

    c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

    Actively involve the human services disciplines in the design of programs and their rules. Work to assure that new programs and/or rules don't set the client up to be in the middle of a conflict between two agencies/organizations. Understand that in many communities, many of the highest cost situations have some level of human services system involvement.

    d. What are the gaps in care coordination across the continuum of care?

    The largest gap we see is ineffective, incomplete or non-existent communication with the behavioral health system.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	XX	☐	XX	
Affordability (assistance with prescriptions or co-pays)	XX	☐	XX	There may not be local supports for this one. Possibly if the RCCO's can work with pharmaceutical companies for programs to offer regional discounts for participating members?
Daycare / childcare	☐	XX	☐	
Economic stability & employment	☐	XX	☐	
Education	☐	XX	☐	
Environment	XX	☐	XX	
Food access / nutrition	XX	☐	XX	
Health literacy	XX	☐	XX	
Housing	XX	☐	XX	
Language or translation services	XX	☐	XX	
Literacy	☐	XX	☐	
Transportation	☐	XX	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	XX	☐	Any provider that bills Medicaid for services should be required to coordinate care in the ACC Program.
Certified Addiction Councilors	XX	☐	Any provider that bills Medicaid for services should be required to coordinate care in the ACC Program.
Certified Nurse Midwives	XX	☐	Any provider that bills Medicaid for services should be required to coordinate care in the ACC Program.
Community Health Workers	XX	☐	
Generalists (BA/BS/MA/MS)	XX	☐	Any provider that bills Medicaid for services should be required to coordinate care in the ACC Program.
Health Coaches	XX	☐	
Licensed Clinical Social Workers	XX	☐	
Licensed Marriage and Family Therapist	XX	☐	Any provider that bills Medicaid for services should be required to coordinate care in the ACC Program.
Licensed Mental Health Counselors	XX	☐	Any provider that bills Medicaid for services should be required to coordinate care in the ACC Program.
Licensed Professional Counselor	XX	☐	Any provider that bills Medicaid for services should be required to coordinate care in the ACC Program.
Masters of Public Health	XX	☐	
Medical Doctors / Doctors of Osteopathic Medicine	XX	☐	Any provider that bills Medicaid for services should be required to coordinate care in the ACC Program.
Nurse Practitioners	XX	☐	Any provider that bills Medicaid for services should be required to coordinate care in the ACC Program.
Patient Navigators	XX	☐	
Peer Advocates	☐	XX	
Promotoras	☐	☐	
Psychiatrists	XX	☐	Any provider that bills Medicaid for services should be required to coordinate care in the ACC Program.
Psychologists	XX	☐	Any provider that bills Medicaid for services should be required to coordinate care in the ACC Program.

Registered Nurses	XX	☐	Any provider that bills Medicaid for services should be required to coordinate care in the ACC Program.
Social Workers	XX	☐	
Wraparound facilitators	XX	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	XX	☐	
Children	☐	XX	
Children who are healthy, but in socially-complex environments	☐	XX	
Children involved in the foster care system	XX	☐	
Children with a chronic illness	XX	☐	
Children with a serious emotional disturbance	XX	☐	
Children with medical complexity	XX	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	XX	☐	
Transition-age adolescents	☐	XX	
Parents and families	☐	XX	
Pregnant women	XX	☐	
Adults	☐	XX	
Adults who are healthy, but in socially-complex situations	☐	XX	
Adults with a chronic illness	XX	☐	
Adults with a behavioral health diagnosis or substance use disorder	XX	☐	
Clients involved in the criminal justice system	XX	☐	
Clients with a disability	XX	☐	
Clients in a nursing facility	XX	☐	
Elderly clients	☐	XX	
Frail elderly clients	XX	☐	
Clients in palliative care	XX	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

All parties involved need to be able to communicate openly with each other regarding the needs of these individuals without barriers, such as HIPAA and FERPA, so that the best possible coordination of services can take place.

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

    a. What is the PMPM cost for providing care coordination services?

    b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

    a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

All of the above seem like logical first steps at creating consistency in delivery of care coordination across the State.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs? Minimum of quarterly meetings with community entities.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

Interesting idea, but if I live in Mesa County, and one of my providers is in one RCCO, and my child's provider is in another RCCO, I can see that this could lead to less coordinated care for the family as a whole. If providers are asking for this option, then that leads me to believe that some level of consistency among the RCCO's would be preferable.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment? Any medical service delivery should be coordinated.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services? From a case management perspective (for example in Child Welfare), there should be coordination just as there would amongst other medical providers. From an Assistance Program perspective, referrals can be made to DHS to encourage individuals to enroll in programs they may be eligible for. Ideally providers would be able to know if an individual is participating in Food Assistance/SNAP as well as Medicaid, so they have an idea where a family or individual is at with their nutrition/food stability.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region? Quarterly meetings

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC? Quarterly meetings

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

   a. If no, what are the gaps?

   b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

   a. What role should hospitals play in the next iteration of the ACC Program?

   b. What role should pharmacies play in the next iteration of the ACC Program?

   c. What role should specialists play in the next iteration of the ACC Program?

   d. What role should home health play in the next iteration of the ACC Program?

   e. What role should hospice care play in the next iteration of the ACC Program?

   f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

   g. What role should counties play in the next iteration of the ACC Program?

   h. What role should local public health agencies play in the next iteration of the ACC Program?

   i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

For many Medicaid participants, future time is a concept that can't always be set in stone, because the next crisis in their life could change their plans very quickly. I would recommend not scheduling appointments out more than three days in advance, and doing a reminder call either the day before or the day of the appointment. Transportation is a common barrier, so discuss with the individual at the time the appointment is scheduled what their plans are for how they will get to the appointment, so they are thinking about it then and not 30 minutes before the appointment.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP? This would be beneficial.

47) **Community Health Worker reimbursement**. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers? Oral health should be coordinated in the same way as any other health care need.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care? Yes

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend? Counseling with these individuals at the time of service in the emergency room on what alternative options they could have accessed instead of the ER. Interview these individuals to determine why they chose the ER over the alternative options. From what I have heard from individuals is that the ER is fast and accessible. Getting into a doc requires an appointment, and many people are solidly in the mindset of the present and don't want to wait or feel they can't wait. That is a tough one to overcome. Some folks also want to stay off the radar to the degree that they don't want a "record" with Medicaid or a Primary Care Provider, so they just show up to the ER when care is needed to avoid what they perceive to be a "record".

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured? Possibly create an electronic assessment that providers can complete at the time of each visit. Something that would be consistent across all providers.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☐
Care management tool	☐	☐	☐	☐	☐
Care transitions alerts	☐	☐	☐	☐	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☐	☐	☐	☐	☐
Health risk assessment software	☐	☐	☐	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	XX
Patient education wellness tools	☐	☐	☐	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☐
Shared decision-making tools	☐	☐	☐	☐	☐
Telemedicine	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 111

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Valerie L. Corzine, Esq.
Location: Centennial, CO 80122

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Orchid Mental Health Legal Advocacy of Colorado, Inc.
Location: Centennial, CO 80122
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☒ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☐ Yes
☒ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
No I have not been involved. I have been involved with people with mental illness who are homeless, as well as the many who are incarcerated.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Involvement as an attorney/advocate for individuals with "mental illness" who are homeless or incarcerated.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☒ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

2) What is not working well in the ACC Program?

   The biggest problem is that critical "Social Determinants of Health" such as housing are not adequately covered.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

4) What is not working well in the BHO system?

   Shortage of access to Assertive Community Treatment (ACT) and the critical "Social Determinant of Health" – housing.

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

   See above.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Recognition and full funding of the essential "Social Determinant of Health" -- housing

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☒	☐	The social determinant of health – housing as well as assertive community treatment are not cheap AND they are ESSENTIAL
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☒	☐	Assertive Community Treatment must be available to all where it is reasonably medically necessary & NOT artificially restricted.
Staff capacity	☒	☐	People who are coming out of incarceration or at risk of incarceration or homeless may have significant supervision needs, although they do not need to be hospitalized. That is beyond a training issue although it is important – it requires significant greater number of FTEs than the system currently has.

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☒	☐	Staff need to be trained in the Finnish model of "Open Dialogue" which has a proven record of reducing medication use and hospitalizations. Univ. of Massachusetts, Dept. of Psychiatry, recently completed project to adapt "Open Dialogue" to the US.
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

Able to provide critical & essential "Social Determinants of Health" – most importantly, housing.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Need holistic approach:

1. Best Science from the Nat'l Institute of Mental Health as well as SAMHSA

2. Reduce time that evidenced based practices get to mental health individuals – average now is 17 yrs.

3. Person directed recovery

5. Peer Run Services

6. Intensive Services such as Assertive Community Treatment (ACT) to prevent homelessness or institutionalization, including incarceration.

7. Make access to critical "Social Determinants of Health" such as housing – easy. Make it a one-stop shop

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

Ideally physical and mental health provided in same clinics with mental health experts providing mental health care and physical medicine experts providing that care.

b. How should RCCOs prioritize who receives care coordination first?

c. How should RCCOs identify clients and families who need care coordination?

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☐	I would refer to all "non medical needs" as "Social Determinants of Health" as recognized by the World Health Organization (WHO) and the Centers for Disease Control (CDC).
Affordability (assistance with prescriptions or co-pays)	☒	☐	☐	
Daycare / childcare	☒	☐	☐	
Economic stability & employment	☒	☐	☐	
Education	☒	☐	☐	
Environment	☒	☐	☐	
Food access / nutrition	☒	☐	☐	
Health literacy	☒	☐	☐	
Housing	☒	☐	☐	
Language or translation services	☒	☐	☐	
Literacy	☒	☐	☐	
Transportation	☒	☐	☐	

Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☐	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☐	☐	
Social Workers	☐	☐	

Wraparound facilitators	☐	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations**. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☐	☐	
Transition-age adolescents	☐	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☐	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☐	☐	
Clients involved in the criminal justice system	☐	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

    a. What is the PMPM cost for providing care coordination services?

    b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

    a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☒
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

Social Determinants of Health – especially Housing

Intensive Supervision short of institutionalization – ACT – Assertive Community Treatment

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

Hospitals should arrange housing for homeless clients such as in Minnesota.

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47) **Community Health Worker reimbursement**. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☒	☒
Network provider education	☒	☐	☒	☒
Assistance with practice redesign	☒	☐	☒	☒
Assistance with efficiency-enhancing activities	☒	☐	☒	☒
Provide web-based resources and directories	☒	☐	☒	☒
Provide practice-specific data reports	☒	☐	☒	☒
Provide clinical care guidelines and best practices.	☒	☐	☒	☒
Provide clinical screening tools	☒	☐	☒	☒
Provide health and functioning questionnaires	☒	☐	☒	☒
Provide chronic care templates	☒	☐	☒	☒
Provide registries	☒	☐	☒	☒
Offer client reminders	☒	☐	☒	☒
Offer client self-management tools	☒	☐	☒	☒
Offer educational materials about specific conditions	☒	☐	☒	☒
Supply behavioral health surveys	☒	☐	☒	☒
Supply other self-screening tools	☒	☐	☒	☒
Administer behavioral health surveys	☒	☐	☒	☒
Administer other self-screening tools	☒	☐	☒	☒
Prepare client action plans	☒	☐	☒	☒
Provide training on providing culturally-competent care	☒	☐	☒	☒
Provide training to supporting staff	☒	☐	☒	☒
Provide training on motivational interviewing	☒	☐	☒	☒
Provide tools and software for phone call and appointment tracking	☒	☐	☒	☒
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☒	☒
Provide referral and transitions of care checklists	☒	☐	☒	☒
Provide visit agendas or templates	☒	☐	☒	☒
Provide standing pharmacy order templates	☒	☐	☒	☒
Provide comprehensive directory of community resources	☒	☐	☒	☒
Provide directory of other resources	☒	☐	☒	☒
Provide materials regarding Nurse Advice Line	☒	☐	☒	☒
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☒	☒
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☐	
SF-12 Health Survey	☒	☐	
Other types of client interviews / surveys	☒	☐	
Patient Activation Measure	☒	☐	
Focus groups	☒	☐	
Other	Please type your response here.		

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 112

Accepted by: KJDW

Notes:

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Jason L. Herndon, Ph.D.
Location: Denver, Denver County, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Click here to enter text.
Location: City, County, State.
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Clinical Psychology
  ii. Area of practice: Primary Care
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☐ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Click here to enter text.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?
2) What is not working well in the ACC Program?
3) What is working best in the Behavioral Health Organization (BHO) system right now?
4) What is not working well in the BHO system?
5) What is working well with RCCO and BHO collaboration right now?
6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

The next step should be addressing the significant challenges related to billing for integrated behavioral health services within primary care settings. Because the services that I am able to bill Medicaid for are so limited and specific, it makes sustainability difficult to attain. It seems that the ACC agrees that behavioral health integration is important, yet financial sustainability aspect of these services has yet to be adequately addressed. Appropriately addressing the billing challenges associated with these services will then make it possible to scale these services to community practices across the state.

Related to the challenge of billing are the challenges associated with the use of various screening measures within these settings. Screening and early identification of a variety of types of developmental and behavioral health concerns is essential to effective practice in integrate behavioral health. While some important screeners are billable, most are not, which requires providers (both medical and behavioral) and practices to choose between identifying concerns and being reimbursed for their time. Expanding the list of covered screening tools to include broad-based measures of emotional well-being and psychosocial needs is an integral next step in behavioral health integration.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☒	☐	
Different behavioral / physical health reimbursement	☒	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☒	☐	
Privacy Laws (HIPAA, 42 CFR)	☐	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	☐	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☒	☐	
Training	☐	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

The minimum requirements for a clinic to be recognized should be the presence of an on-site mental health professional that is appropriately-trained and educated to provide integrated behavioral health services. While there are a variety of models, as outlined in HRSA's Six-Level Framework for providing these integrated services, ideally clinics will have a plan in place to transition to a more fully integrated model of service delivery over time. Often, the co-located model takes the form of providing traditional mental health services in a primary care setting. This is not the goal of integrated behavioral health care. While co-located care certainly has significant benefit to clinics and patients, ultimately a fully integrated system has the greatest chance of meeting whole-person/whole-family physical and behavioral health care.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 113

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

Colorado Department of Health Care Policy and Financing

REQUEST FOR INFORMATION

(RFI UHAA 2015000017)

Accountable Care Collaborative Request for Information

Response from Colorado Children's Campaign

November 24, 2014

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Cody Belzley
Location: Denver, Denver, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Children's Campaign
Location: Denver, Denver, CO
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): statewide, non-profit, non-partisan child advocacy organization

Are you currently involved in the ACC program?

☐ Yes
☒ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:
The Colorado Children's Campaign has had no direct involvement with the ACC program. We work with RCCOs in advocacy efforts.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
The Colorado Children's Campaign has long advocated to expand, strengthen and improve operations of public health insurance programs in Colorado, including Medicaid.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☒ Will not seek to participate
☐ N/A

We are not a direct service provider, nor do we seek to be.

General Questions

What is working best in the Accountable Care Collaborative (ACC) right now?

We are pleased that Colorado has implemented the Accountable Care Collaborative (ACC) program. Fee-for-service health care delivery is an inefficient and ineffective model and there are many challenges with a fully-capitated managed care model. The ACC approach is an appropriate solution. We are pleased that the State is taking such a thoughtful approach to how to strengthen and improve the program. *Thonk you for seeking stokeholder input prior to developing ond releosing the request for proposols to prospective controctors.*

It makes sense to take a regional approach that recognizes variations in population, culture and health care delivery systems and patterns across Colorado. We appreciate that the current Regional Care Collaborative Organizations (RCCOs) are Colorado-based companies and collaboratives. It is much easier to work with and learn from them when they are already embedded in our communities, connected with provider and consumer groups and have executives with decision-making authority here in Colorado.

We appreciate that the Key Performance Indicators (KPIs) are clearly identified and consistent across the program. While we don't believe it is sufficient, we do appreciate that well-child visit is included in the KPI set.

What is not working well in the ACC Program?

Our chief concern is that the ACC program is primarily oriented towards health care for adults and the intervention and management of chronic conditions. This is true despite the fact that more than half of Medicaid clients and ACC enrollees are children and adolescents. Given the demographic make-up of the program's population, children should not be considered a "subgroup" population. Rather, children should be considered a primary population and a new pediatric-specific strategy should be implemented. The principles underlying the pediatric strategy should include:

- Focus on prevention. For most children, health care services focus on preventing the development of chronic conditions, not management chronic conditions. Where prevention is not possible, early identification and intervention is essential.
- Ensure family-centered care. The vast majority of children do not operate independently of their adult care-givers. Patient-centered care in a pediatric context must include care coordination and support for the family unit (recognizing that family will be defined differently in differing contexts). This is particularly true for infants, toddlers and young children who are deeply impacts by the health and stability of their family unit.
- Connect with community. Many children and families have strong connections to community-based programs and services, including early care and education providers and the K-12 education system. The ACC program, through the RCCO contractors, should be closely connected to community programs, supports and services for low-income children and families. Examples of these include but are not limited to:
    - Maternal, infant and early childhood home visitation programs
    - Early Childhood Councils
    - Child care health consultants, as managed by Healthy Child Care Colorado, a program of Qualistar

  - School-based health centers
- Take the long and broad view on evaluation. The provision of prevention services requires up-front investment. The return on that investment can take years, even decades, to materialize. Further, health prevention services for children delivered in a medical setting can produce savings across multiple systems and settings. The State will need to be committed to this work over the long term and develop sophisticated evaluation metrics to measure impact.

While allowing for regional variation is a strength of the ACC program, the current ACC / RCCO map is problematic. It is not well-aligned with natural health care system and referral patterns, nor aligned with Behavioral Health Organization regions, Managed Service Organization regions or Local Public Health Agencies. The map should be redrawn to ensure greater alignment with other program service areas and support more streamlined service delivery to families.

As a data-driven policy organization, we would be very pleased to see more reliable and easy-to-access data and information coming out of the ACC program. Our understanding is that the data systems in place today are flawed, producing delayed and often inaccurate data. This makes it difficult for health care providers to improve service to clients and difficult to evaluate the effectiveness of the program. The Children's Campaign would support the Department of Health Care Policy and Financing (HCPF) in asking the State for additional resources to strengthen the data collection capacity for this program.

The ACC's current exclusive focus on physical health is a concern. We applaud HCPF for using this RFI to collect information on behavioral health integration. We are also committed to advancing access to oral health care services for children and hope that the integration conversation at HCPF will be inclusive of mental, oral and physical health care services.

What is working best in the Behavioral Health Organization (BHO) system right now?

Our sense is that the Behavioral Health Organization (BHO) system works best today for those with serious mental illness, whose primary health care concern is their mental health condition. Having a separated behavioral health system, with separate management and financing, is not beneficial to the vast majority of children served by Medicaid.

Behavioral Health Integration

What should be the next steps in behavioral health integration in Colorado?

We are very pleased that HCPF is carefully considering next steps for behavioral health integration in Colorado and specifically with the Medicaid population. We see tremendous opportunity in behavioral health integration to improve health outcomes and program efficiency.

The next steps for behavioral health integration in Colorado must include:

- Financing and payment reform.
- Practice transformation support.
- Data collection.

Much of this work has been outlined in Colorado's State Innovation Model (SIM) grant proposal. We urge HCPF to continue being a thought leader in the SIM work and using Medicaid to move other payers toward integration. Ensuring alignment between Medicaid and private payers in their payment reform, practice transformation and data collection efforts is essential to having a broader impact on Colorado's population.

Care Coordination

RCCOs' roles in addressing clients' and their families' non-medical needs. Please complete the table below, keeping in mind adults, children, and families:

RCCOs should help health care providers connect to community-based supports and services, not duplicate or replace them.

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☒	
Affordability (assistance with prescriptions or co-pays)	☐	☐	☒	
Daycare / childcare	☐	☐	☒	
Economic stability & employment	☐	☐	☒	
Education	☐	☐	☒	
Environment	☐	☐	☒	
Food access / nutrition	☐	☐	☒	
Health literacy	☐	☐	☒	
Housing	☐	☐	☒	
Language or translation services	☐	☐	☒	
Literacy	☐	☐	☒	
Transportation	☐	☐	☒	

Stakeholder Engagement

What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

As a general rule, client, client family and client advocate engagement should happen as close to the community level as possible. RCCOs should support health care practices in providing higher quality care, inclusive of robust client engagement. The role of the RCCO should be in supporting clients when their provider has failed to do so.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 114

Accepted by: KJDW

Notes: De-identified at request of client's family member. Redacted by order of HCPF Legal.

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

[redacted]

[redacted]

[redacted]

[redacted]

[1] Many terms and definitions can be found in the Appendix at the end of this document.

[redacted]

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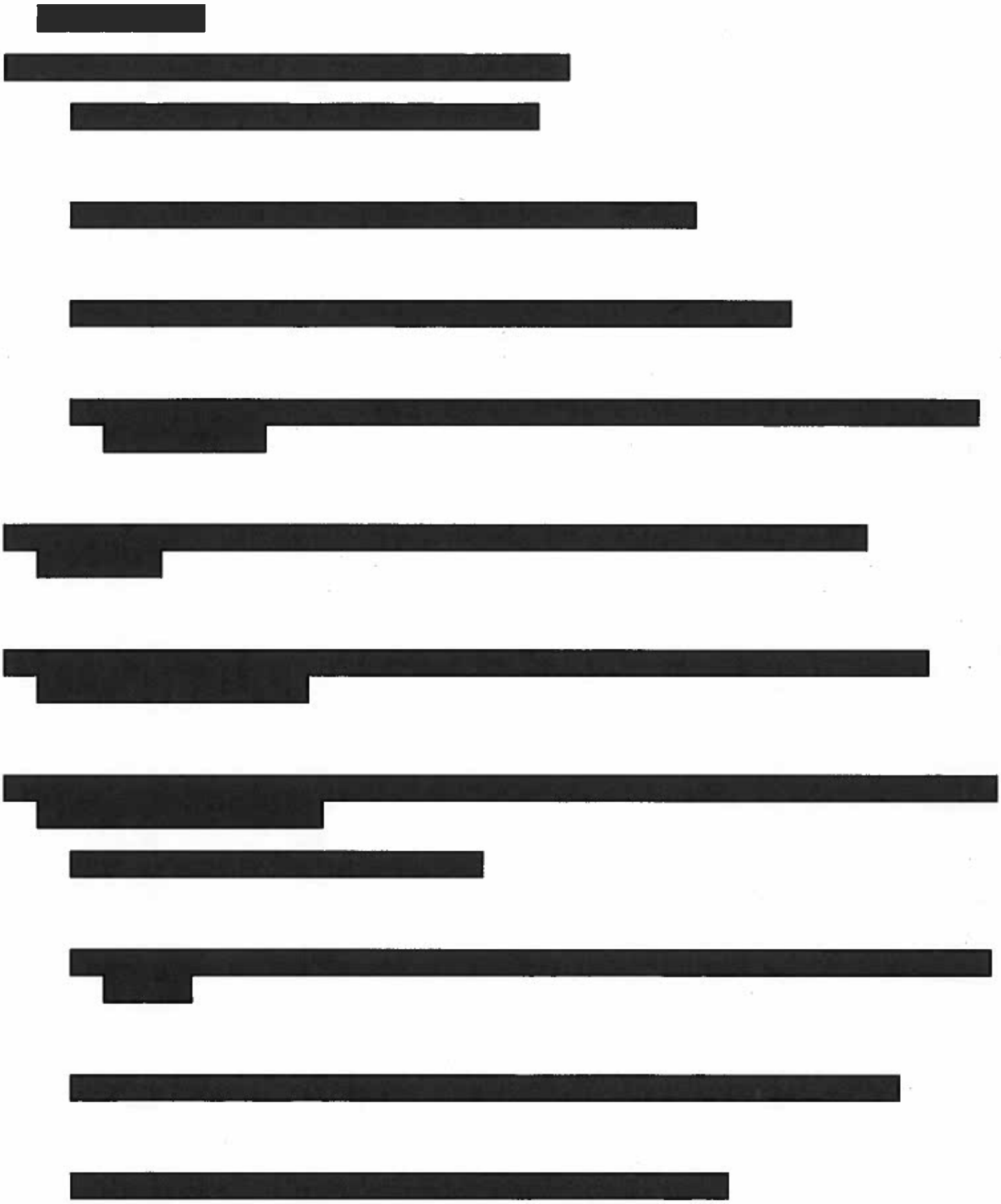
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

[redacted]



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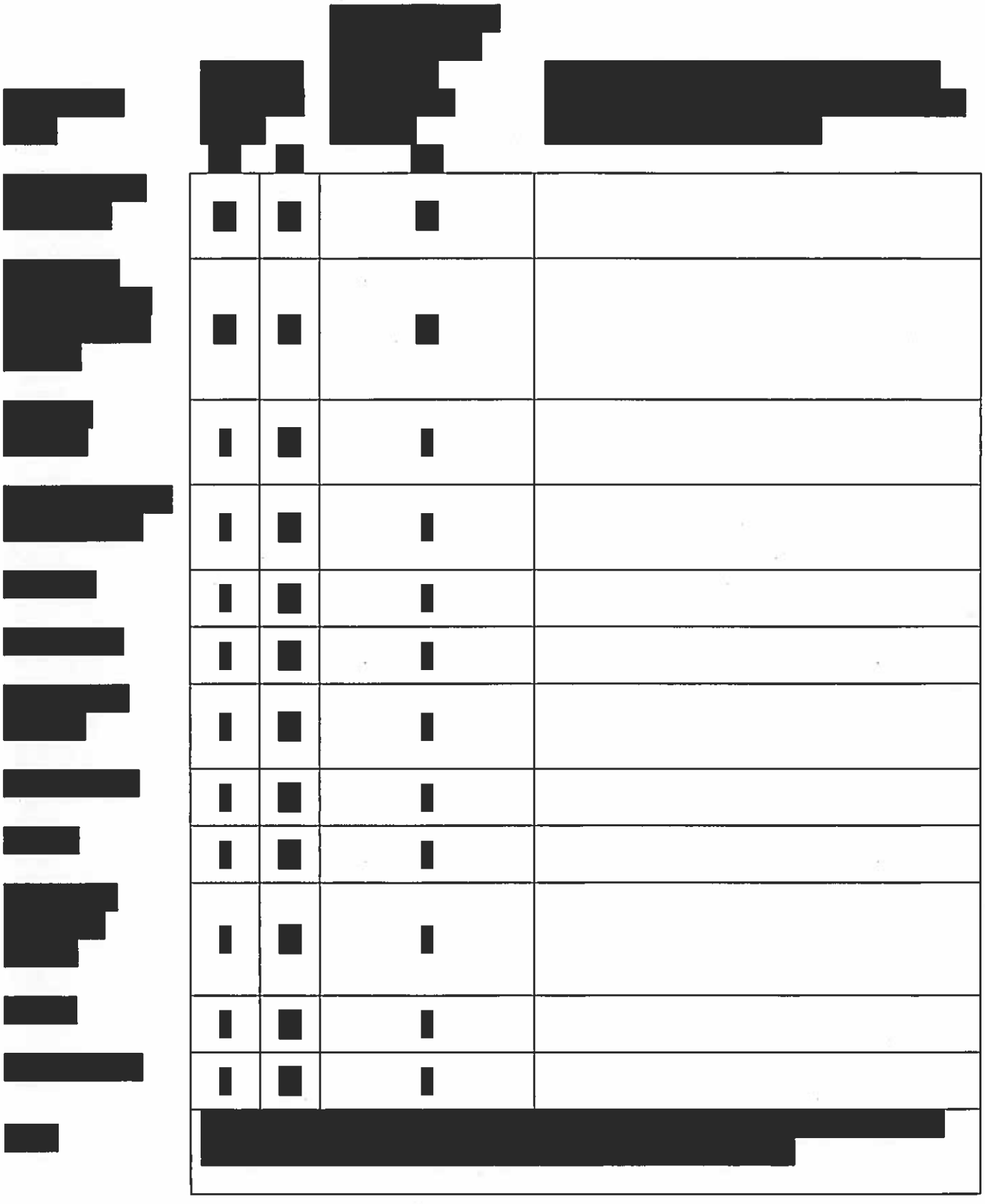

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 115

Accepted by: KJDW

Notes: Formatting standardized

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Barbara J Martin
Location: Denver, Colorado

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: The Colorado Department of Public Health and Environment
Location: Denver, Denver, Colorado
X Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
X Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

X Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
X Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:

The Colorado Department of public Health and Environment (CDPHE) is a strong supporter of the ACC/RCCO program and encourages program staff to seek opportunities to maximize the program.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

CDPHE and Health Care Policy and Finance are sister agencies under the Governor's Office.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

The Accountable Care Collaborative program supports community based care that can best respond to the needs of the clients. In addition, the designated resources for data analysis and care coordination services are transforming how care is experienced in Colorado. Ensuring care coordination for at-risk and vulnerable populations is a key component of the ACC program, and one that support the patient-centered medical home approach.

The inclusion of the key Performance Indicators and the upcoming shared savings component of the ACC model will support the delivery of quality care that is patient-focused and focused on improved health outcomes.

2) What is not working well in the ACC Program?

a. CDPHE would encourage the RCCOs to implement and promote evidence-based population health programs to improve the health of their clients. The RCCO service areas create mini-populations that can be served with population-based and evidence-based programs like the Diabetes Prevention Program, Diabetes Self Management and Education, tobacco cessation services (including the Colorado QuitLine), home blood pressure monitoring programs, and RCCO-wide medication therapy management programs. Rather than creating their own programs we encourage the implementation of evidence-based programs. RCCOs can provide education and promotion of evidence-based services and Medicaid benefits for tobacco cessation directly to Medicaid clients and providers.

b. CDPHE would encourage the development of communities of care that employ a multi-disciplinary team, both within the clinic and community settings, to reduce barriers to care for vulnerable and disparate populations. This may include nurses or pharmacists who can target individuals with multiple chronic diseases for effective medication therapy management, lay patient navigators who can help address barriers to care within the health systems and community setting and/or focus on high utliziers, in addition to the inclusion of more traditional members of the team such as nurse and social workers. Often, Local Public Health Agencies can provide resources and would be an effective partner in developing communities of care.

A good example of how RCCOs can support this is by ensuring that tobacco use and exposure screening is incorporated into clinic settings and referral and benefits promotion to Colorado QuitLine or other community cessation resources can be done via patient navigation or community health workers.

c. CDPHE supports the conversation around data sharing across systems of care while keeping the individual's health information protected. One of the areas most in need of improved communication and sharing of real time data is between the pharmacy and clinic setting. Ideally, data exchange would be real-time, so that, for example, a provider could see when a client picks up a prescription from a pharmacist and a pharmacist would be able to see relevant patient notes (i.e., care plans, behavior modification recommendations, etc.) so that both the provider and pharmacist could reinforce recommendations. Encouraging secure messaging between all care team members is one way to address this.
d. Colorado Department of Public Health and Environment has developed a strong Social Determinants of Health model that incorporates key aspects that contribute to overall population health. RCCOs should be encouraged to pursue policy efforts that enhance the health and well-being of their clients – for example, working with the community on an overall strategy to increase bicycling or walking or with the Local Public Health Agency on its public health improvement plan which may include many policy-related elements.
e. CDPHE supports data driven quality improvement and would like a more robust process for benchmarking and quality improvement among primary care medical providers in a RCCO region. Although there are many ongoing QI initiatives, there is not consistent understanding to the stakeholder community on what this process looks like and what support practices receive from the RCCOs.

Special Population Considerations:

f. CDPHE is focused on older adults risk for falls. Older adults at risk for falls may not be getting adequate assessment, treatment and referral to effective community-based programs that are evidence-based to reduce falls and fall risk factors. CDPHE can provide resources and expertise to support the RCCOs in assessing and serving this population.
g. Lack of any KPIs for oral health limits care coordination to a dental home. A KPI regarding a diagnostic visit to a dentist would help track access to dental home (CMS 416 report, 12 e).
h. CDPHE is focused on tobacco cessation and secondhand smoke (SHS) exposure prevention for pregnant and postpartum women. RCCOs can play a role in promoting evidence-based cessation services specially tailored for pregnant women available through the Colorado QuitLine and Baby and Me, Tobacco Free Program. In-home environmental assessments and asthma interventions for children with asthma which include tobacco/SHS screening is an area of interest for developing reimbursement opportunities. Once home environmental assessment reimbursement is adopted, RCCOs have the opportunity to play a role in disseminating information to Medicaid clients, health care providers and community health service providers. CDPHE can provide resources and expertise to support the RCCOs in increasing tobacco cessation and SHS exposure reduction in this population.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

The Behavioral Health Organizations have developed networks of care delivery for individuals requiring behavioral health services.

4) What is not working well in the BHO system?

The current mechanism of paying for behavioral health services in Colorado may create barriers to accessing care for vulnerable populations and provide a disincentive for physical and behavioral health providers to work together to support patient-centered health outcomes. Evidence supports the integration of physical and behavioral health care which may be impeded by the presence of a mental health carve out. CDPHE supports the State Innovation Model grant application and proposed integration of behavioral health with primary care.

Special Population considerations:

In the current BHO structure, there is minimal access to providers with maternal mental health expertise. Services for pregnant and postpartum women are offered on the adult side of care in community mental health centers while services for infants and children are offered on the family side – creates a disconnect when trying to provide services to a woman in the context of being a new mother. This approach does not support two-generation approaches to mental health care.

In the current BHO structure, children with intellectual and developmental disabilities often have a dual diagnosis of a mental health condition. Because the diagnose are paid for separately, the care is often fragmented and siloed, leading to gaps in care for this population.

5) What is working well with RCCO and BHO collaboration right now?

   The RCCOs have formed close working relationships with the BHOs that serve their region in an effort to address some of the barriers to care that arise from different funding mechanisms. Some of the RCCOs and BHOs are able to share data about clients requiring physical and behavioral health care needs. In the case of Colorado Access, they are the BHO for two of their regions which allows for a more efficient process of identifying patients who may have need of coordination across systems.

6) What is not working well with RCCO and BHO collaboration right now?

   Although there are guidelines and benefits to collaborating, the structure as it is currently in place does not effectively serve all individuals needing physical and behavioral health care. The geographic boundaries of the BHOs do not align with the RCCO boundaries, which adds complexity to the process of collaboration. In addition, the financial disincentives to coordinating care create barriers to the two entities fully collaborating.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

CDPHE supports the State Innovation Model grant application which focuses on integrating behavioral health and primary care to ensure comprehensive, patient-driven care. We recommend assessing and aligning the geographic regions. An additional consideration may be to consider carving in the mental health carve out which would eliminate the disincentive to collaborate.

Special Population Considerations

We recommend exploring how to integrate services for pregnant women, infants and young children and not just the adult population.

We support the Systems of Care grant work that is evaluating wrap around care management for high risk behavioral health adolescents.

We strongly urge evaluation of the continuity of care for children and adults with a dual diagnosis of intellectual or developmental disability and a mental health diagnosis.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☐	☐	
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	X	☐	Dental does not currently use diagnosis codes making outcome measures challenging
Different behavioral / physical health reimbursement	X	☐	If HCPF continues to use FFS for most procedures, make sure all CPT oral surgery codes have been adjusted to 75% of Medicare rates.
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	
PCMP financing structure	☐	☐	
Per-member per-month amount	☐	☐	
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	X	☐	
Professional / cultural divisions	☐	☐	
RCCO or BHO contracts	X	☐	
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Technical resources / data sharing	X	☐	APCD will include dental claims. Since SDAC does not include dental codes, it is very difficult to evaluate the oral health needs at a community level.
Training	☐	☐	
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

CDPHE supports the principles in place to support a medical home approach for Primary Care Medical Providers (PCMPs). We recommend a standard system of assessing competency to meet the identified standards. We support the advance primary care standards and feel that there is an opportunity in the next RCCO re-bid process to assess feasibility of further defining levels of medical home to ensure high quality care for our Medicaid clients. The State Innovation Model grant has provided a framework for integration and is currently developing a process for assessing practices—it will be beneficial to align the ACC model with this work.

Special Population Considerations

- PCMPs should have a process in place for referral to a dental home for at-risk clients
- Community Mental health Centers may serve as a health home for individuals with serious mental health illness.
- School-based health Centers serve many of Colorado's most vulnerable populations in geographic regions with health disparities; they provide mental and dental health to the populations they serve, and should be considered within the context of the ACC program as a PCMP if they meet the requirements.

10) Please share any other general advice or suggestions you may have about behavioral health integration.

In particular for the pregnant and postpartum population, accessing behavioral health services at a mental health center is a significant barrier in itself. The waiting room environment is often cited as not welcoming for a young mother and her baby, and getting out of the home for an extra office visit when there is a small infant at home takes a high level of motivation and organization, which mothers who are depressed often do not have. Often new mothers will not seek out medical care for themselves beyond 2-6 weeks postpartum, but will access the health care system through well child checks for their baby. What are the opportunities for integrating behavioral health into pediatric offices in a way that would allow for support for the mother if she appeared to be having mental health problems? This would go beyond just infant/child therapy, but could be provided in conjunction with it.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

Care coordination delivers health benefits to those with multiple needs by assisting individuals in identifying health goals, supporting healthy decisions and coordinating services and providers to meet those goals. Patient navigation services are provided to assist clients in reducing barriers to health care access including, but not limited to health insurance coverage, screening services, system navigation and behavior change.

b. How should RCCOs prioritize who receives care coordination first?

- There who are high system users (ER or other)
- Clients who have multiple or complex chronic and/or behavioral conditions
- Clients who have complex social needs or cross more than one system of care
- Clients who are on multiple medications;
- Clients who have expressed a need for care coordination
- Clients who do not seek services and care due to social barriers to care, i.e., monolingual or English as a second language populations, residing in food desert areas, transportation issues, high perceptions of ethnic/racial discrimination in healthcare settings
- A tiered care coordination program that includes a focus on prevention, and health promotion: Utilize claims data to determine lapses in well-care, immunizations, and preventive screening, and develop outreach protocols

c. How should RCCOs identify clients and families who need care coordination?

- Claims data and risk stratification tools
- Health Risk Assessment
- Client request
- Newly diagnosed or acute exacerbation of a chronic disease such as COPD, diabetes, cancer, cardiovascular disease
- Utilization across systems
- Transitions in Care (Hospital discharge, discharge from behavioral health or substance abuse facility, youth with special health care need transitioning to adulthood, transition out of correctional system)

Special Population Considerations

All older adults age 65+ would benefit from fall risk assessment and then a specific plan of care if needed (2+ falls or any fall with injury). Older adults not requiring a plan of care would benefit from a discussion/education session (emphasizing patient activation) on reducing risk of falls and referrals to community resources such as evidence-based fall prevention programs.

For older adults, the transition from hospital/health facility discharge or emergency room visit back to the home is a time of increase risk for falls. This could be a flag for care coordination.

Pregnant women with Medicaid are almost three times as likely as those with other insurance to smoke and are at high risk for postpartum relapse. Tobacco use and secondhand smoke exposure screening, referral to cessation services such as the Colorado QuitLine and promotion of Medicaid cessation benefits should be prioritized at all encounters and at all points of care for women during pregnancy and postpartum periods.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

   Tracking and evaluation of care coordination are two essential components necessary for the evolution of the ACC model. A shared care plan is often identified as a solution and much harder to implement. We nonetheless suggest working towards a patient-centered solution that supports sharing information across systems. NQF published a summary document identifying the different measures that might be considered within the realm of care coordination:

   http://www.qualityforum.org/News_And_Resources/Endorsement_Summaries/Care_Coordination_Endorsement_Summary.aspx

   Establishing a dummy code to track care coordination is one method that might track care coordination, however given the constraints of the system and the transition to a new platform we are not sure of the feasibility of this. We do recommend that the ACC model support a singular platform for care coordination documentation across the state.

12) What services should be coordinated and are there services that should not be a part of care coordination?

The following services should be coordinated:

- Referrals to community based prevention and management programs (i.e. Colorado QuitLine , Baby and Me Tobacco Free Program, Diabetes Prevention Program)
- Comprehensive age and risk appropriate preventive services management, including follow-up to treatment/specialty care when needed (i.e. cancer screening and connection to treatment)
- Medication therapy management and collaborative drug therapy management

- Behavioral health care services, particularly amongst those with high need but underutilization of services
- Social services, including transportation, housing, and community resources
- For adults with a concurrent medical condition/diagnosis-particularly diabetes and heart disease, care should be taken to coordinate services between the medical specialist and dental provider.
- Preventive oral health services between medical and dental providers.
- RCCOs include Cavity Free at Three messaging in provider communications. RCCOs encourage primary care providers, including family practice physicians, pediatricians, ob/gyns, physician assistances and nurse practitioners, to contact CDPHE for Cavity Free at Three training. (Medicaid and CHP+ requires certification to bill for Cavity Free at Three medical services)
- Add Medicaid dental providers to RCCO communications. Encourage dental providers to receive Cavity Free at Three training.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

It is important to identify the psychosocial, housing and food security risk factors and barriers to care in additional to health indicators. Emotional and financial resources to support the management of an illness often appear to be the drivers for success more so than the medical care itself.

A comprehensive health risk assessment could capture the above information in addition to medical conditions (to determine complexity of conditions, i.e., multiple chronic conditions, cancer survivorship); preferred language; perceptions of ethnic and racial discrimination as barriers to engagement and social support networks. This assessment should also identify gaps in care, preventive services (screenings, immunizations, family planning, etc), or untreated dental needs that may need to be addressed.

For older adults it is a history of falls and self-assessment done by patient of their falls risks. One example of this is from the CDC STEADI toolkit
http://www.cdc.gov/HomeandRecreationalSafety/pdf/steadi/stay_independent.pdf

For children, additional information about the needs of the family or caregiver, the home environment, as well as potential gaps in access to well care and preventive care as well as untreated dental needs

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

    a. What care coordination is going on today?

CDPHE has multiple programs that provide or support care coordination and management. We would like to communicate to the RCCOs about these programs and provide support and resources for the special populations identified.

The Women's Wellness Connection (WWC) program at CDPHE has initiated a care coordination program for breast and cervical cancer screening and diagnostics for eligible insured (including Medicaid) women. WWC has offered these services to eligible uninsured women for many years.

CDPHE's Tuberculosis Program is tasked by statute with oversight of all TB prevention and control activities throughout Colorado. The TB Team has the expertise to support case management topics including: proper drug treatment; drug susceptibility testing; diagnostics including chest x-rays, collecting sputa, and skin or blood tests for TB infection; capacity building and training of new staff tasked with TB care and treatment; and contact investigations, to name a few.

The CDPHE Tuberculosis (TB) Program is particularly interested in coordinated care for those with co-morbid conditions including HIV, diabetes mellitus, and Hepatitis C along with behavioral/lifestyle conditions including smoking, chronic alcohol use, illicit drug use, homelessness, and incarceration. We have the resources and knowhow to support RCCOs in all these areas and more. We also coordinate care for recent foreign-born arrivals and Class Bs with indications of current or prior exposure to TB.

The CDPHE Viral hepatitis Program (VHP) utilizes case managers. The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit (Grade A). The ACIP recommends hepatitis B vaccination at birth and recommends vaccination of all household and sexual contacts of a person with hepatitis B infection. The VHP assures that pregnant women are screened and that the woman, her newborn, and any household or sexual contacts are educated, counseled, tested and offered vaccine as needed.

The VHP includes 2 case managers and a nurse educator (shared with Immunization Program). Each year, the case managers serve 140-150 women with newly identified pregnancies and their newborns. More than half of these women were born in endemic countries, primarily Asia and Africa. These women need language interpretation services. A similar proportion receive Medicaid or are Medicaid eligible.

In addition to testing and vaccination services, the case managers provide coordination of care and education. As needed or requested by the woman, CDPHE can send a case manager to the home or send the client to a LabCorps or Quest for hepatitis blood draws. The case managers also work with local health departments to assure that infants and contacts can be vaccinated.

The nurse educator promotes the birth dose to hospitals around the state. Working with the program manager, the program identifies facilities that are not administering a birth dose of hepatitis B or are administering it to <90% of their birth cohort. These hospitals are prioritized, and the nurse manager arranges visits with the leaders at the facility to discuss their ranking, their challenges, and opportunities.

The Colorado Department of Public Health and Environment Health Care Program for Children and Youth with Special Health Care Needs is a community-based care coordination program for the children and youth in Colorado. HCP supports families to manage a wide range of questions, concerns and services for their child with special health care needs through:

- Information and resources
- Individualized care coordination
- Access to specialty care for children and youth statewide by helping families get referrals to and from specialized care and hosting specialty clinics in rural locations
- Supporting a medical home approach/local systems building
- HCP consults with providers and local organizations that have questions about children and youth with special health care needs.

WIC provides nutrition education, breastfeeding support and food benefits to pregnant and postpartum women and children 0-5. WIC also screens and refers for other common health issues.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

Prenatal Plus and Nurse-Family Partnership:
Care coordination for pregnant women occurs through programs such as Prenatal Plus and Nurse-Family Partnership; however the level of intensity is significantly different. These programs meet in person with each participant on at least a monthly basis or more often throughout the pregnancy and discuss a variety of issues related to health, substance use, mental health and nutrition. The providers are trained in working specifically with this population. The challenge is that not all women receive this level of services.

Colorado Heart Healthy Solutions:
Many systems employ or contract with community-based organizations to provide community health worker services, however the services may be different from contract to contract based on needs, payment models or other circumstances. Systems like Colorado Heart Healthy Solutions track referrals, risks for cardiovascular disease, and biometric data for clients across the state. Hospital systems and clinic networks, like Metro Community Provider Network, hire patient navigators for specific diseases like assisting patients after cancer diagnoses to ensure they can access system and community services.

Tri-County Health Network:
Patient Health Navigators (PHNs) educate and follow-up with patients at-risk for cardiovascular disease and diabetes, or diagnosed with COPD to improve patient's chronic disease self-management. "Lay-leaders" (PHN and community health workers embedded in the partner clinics provide the Chronic Disease Self-Management Program (CDSMP) six week course throughout the region.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

The Colorado care Coordination collaborative (4C), a partnership between HCPF, Colorado Access, CDPHE, and Tri-County Health Department is piloting a project to identify policy and systems change interventions to improve communication and coordination across care coordination programs serving the children and youth population. This model pilot may be replicable across different RCCO regions.

If a woman is eligible and interested in receiving the more intense level of care coordination through one of the dedicated prenatal programs, the best thing the ACC can do is provide a referral to the program and follow-up to ensure the woman is connected to services. If a woman is already involved in this level of care coordination, the best way the ACC can help is to ensure coordination between the service providers (e.g. Is the medical provider connected to the Prenatal Plus provider and aware that the woman is participating in these services and is there an opportunity to maintain communication between the two providers?)

d. What are the gaps in care coordination across the continuum of care?

There is currently no mechanisms to determine who is receiving care coordination, what the intervention is (information and referral, a more complex family-centered goal to connect to social resources and coordinate with the school) and if it is effective.

For older adults, the transition from hospital/health facility discharge or emergency room visit back to the home is a time of increase risk for falls. Hospital discharge planners may address some of the needs, but there may be unidentified needs such as home safety, medication management, addressing balance and strength, etc. that may need to be transferred to the PCMP care coordination.

There is no consistency across the state about follow-up with postpartum women when they are discharged from the hospital.

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	X	☐	X	Educating providers about mandated requirements and processes to report abuse and neglect
Affordability (assistance with prescriptions or co-pays)	X	☐	X	
Daycare / childcare	X	X	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	Coordination and/or provision of Chronic Disease Self-Management training or DPP classes particularly for vulnerable populations Cultural Responsiveness Training for Healthcare Providers and clinic staff
Environment	X	☐	X	For older adults the home environment may include fall risks. RCCOs could provide referrals, and possible reimbursement for assessment and home safety equipment. For children with asthma at high risk for ER or hospitalization a home environmental assessment
Food access / nutrition	X	☐	X	Referral and counseling as appropriate, to include lactation support; provision of recommended preventive services; use of community health workers to support culturally appropriate health behavior change; referrals to WIC for pregnant/postpartum women and children ages 0-5.

Health literacy	X	☐	X	This is an essential component of support access to care, prevention and health promotions
Housing	X	☐	X	Collaborate with housing and human services for at-risk populations; potential to implement community health worker in areas of high disparities that could be housed within the housing infrastructure.
Language or translation services	X	☐	X	Support use of designated translated or translator services that do not use a family member or friend to translate.
Literacy	☐	☐	☐	
Transportation	X	☐	X	Identified as the number one barrier to care in our recent statewide Maternal Child Health needs assessment.

Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved. Community based programs that address older adult fall prevention are evidence-based to result in decreased falls, decreased fear of falling, and increased quality of life. RCCOS should have a role in referrals to evidence-based community programs. The ideal role would be to assist older adults in locating and enrolling in these programs and feedback to PCMP on enrollment and completion by the patient of these programs. Supporting Dentists, dental hygienists within the medical neighborhood and as the dental home when appropriate. Cross-training of role of medical and dental providers in maximizing prevention and dental care for vulnerable populations. Support population based strategies in collaboration with CDPHE and the LPHAs.

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	X	☐	Provide clinical care, order and interpret lab and diagnostic tests, make recommendations based on evidenced based practice. Oversee clinical aspects of care, especially abnormal values. Initiate and follow-up on referrals, provide complex care management to at-risk clients.
Certified Addiction Councilors	X	☐	Within behavioral health setting
Certified Nurse Midwives	X	☐	Provide clinical care, order and interpret lab and diagnostic tests, make recommendations based on evidenced based practice. Oversee clinical aspects of care, especially abnormal values. Imitate and follow-up on referrals, provide complex care management to at-risk clients.
Community Health Workers		X	Note: we do not believe that community health workers have the knowledge and skills to provide care coordination and ask that you refer to these individuals as patient navigators. Community Health Workers work in community settings and Patient Navigators are related to health systems.
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	X	☐	Coaches should be trained on the risk of falls for older adults and the understanding that fear of falling impacts with older adults' independence, lack of mobility and reluctance to participate in fall prevention programs, as well as chronic disease prevention and nutrition and physical activity promotion programs. They could also be trained in Healthy Eating Active Living support. Motivational Interviewing, connect to resources to support health behavior change. Example: Motivational Interviewing with tobacco user to increase readiness to quit and willingness to participate in evidence-based cessation practices and services.
Licensed Clinical Social Workers	X	☐	Care management and coordination across complex systems of care, work within behavioral health setting may be as primary therapist.

Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	X	☐	Can direct and provide all aspects of medical care. Support team-based care approach.
Nurse Practitioners	X	☐	See above for APN
Patient Navigators	X	☐	Serve to remove barriers to care for vulnerable populations and assist in navigating complex health systems and link to community resources. Can coordinate referrals to evidence-based prevention and management programs and connections to other needed services like transportation, child care, housing, food, etc.
Peer Advocates	X	☐	For those with behavioral health needs
Promotoras	X	☐	Can coordinate referrals to evidence-based prevention and management programs and connections to other needed services like transportation, child care, housing, food, etc. These community based workers can assist patients in locating and enrolling in evidence-based older adult fall prevention programs, and can individually assist in overcoming the barriers older adults have to enrolling in these programs. Health promotion, including obesity prevention. Referrals to Healthy Eating, Active Living programs, WIC. Connect to health care services, connect to community resources.
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	X	☐	Complex patient navigation, care coordination and case management
Social Workers	X	☐	Especially for individuals and families with complex psycho-social needs and or crossing systems of care.
Wraparound facilitators	X	☐	For those at highest risk for complex behavioral health or social needs, or in crisis.
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	X	☐	Newborn hearing screening follow-up, well-check within 3-5 days of birth.
Children	X	☐	Developmental and social-emotional screening follow-up (if screened, did they make it to the evaluation agency)
Children who are healthy, but in socially-complex environments	X	☐	WIC referrals for ALL children and ALL pregnant women; comprehensive needs assessment; The Healthy Lifestyle Screening tool developed by HealthTeamWorks would be very useful.
Children involved in the foster care system	x	☐	Higher intensity care coordination
Children with a chronic illness	X	x	Family-centered approach to care coordination across systems of care including coordination with MH, the school system
Children with a serious emotional disturbance	X	☐	
Children with medical complexity	☐	X	
Children or youth with a behavioral health diagnosis or substance use disorder	X	☐	Higher intensity care coordination and consideration of CM and wraparound services.
Transition-age adolescents	☐	☐	Those with special health care needs need higher intensity CC and a multi-disciplinary transition plan.
Parents and families	☐	☐	
Pregnant women	☐	X	Pregnancy-related depression screening follow-up, smoking cessation services, substance abuse programs (i.e. Special Connections), referrals to appropriate home visitation or prenatal care coordination programs, family planning postpartum, lactation support postpartum, WIC referrals.
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	X	☐	May require care connection to systems outside of the medical arena including social services, detention,
Adults with a chronic illness		X	May require care connections to pharmacy, specialty care providers,

			community-based prevention and/or management programs
Adults with a behavioral health diagnosis or substance use disorder	X	☐	May require extensive pharmacy coordination services; care coordination across systems of care with a shared care plan
Clients involved in the criminal justice system	X	☐	May require extensive pharmacy coordination services; care coordination across systems of care with a shared care plan
Clients with a disability	☐	X	May require extensive pharmacy coordination services; care coordination across systems of care with a shared care plan
Clients in a nursing facility	X	☐	Along with clients utilizing home care services, clients in nursing facilities may require complex pharmacy coordination services, connection to community-based chronic disease prevention or management services, and/or social supports
Elderly clients	X	☐	May require complex pharmacy coordination services, connection to community-based chronic disease prevention or management services, and social supports Older adults over age 65 should be assessed for fall risks, and treated and referred for medical conditions, as needed, and counseled about fall risk prevention options, including community fall prevention programs.
Frail elderly clients	X	☐	May require complex pharmacy coordination services, connection to community-based chronic disease prevention or management services, social supports, community education efforts (fall prevention) Frail older adults over age 65 should be assessed for fall risks, and have a falls plan of care, including home or facility based physical therapy or community fall pre3vneiotn programs.
Clients in palliative care	X	☐	
Other populations, please comment:			

Clients for whom English is a second language; immigrant clients, clients with complex pharmacy needs;
Families of clients who are high utilizers, including families of children requiring operating room dentistry to manage dental disease.
Ethnic/Racial populations and self-identified LGBTQI individuals with perceptions/experiences of discrimination in healthcare settings.

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

There needs to be a communication loop that can help ensure wrap around services are being provided when necessary. Consider braided or blended funding for medically or socially complex children or those in the foster systems so that different payer sources do not become a barrier. Identify one lead agency to coordinate care and assess a shared care plan. The Systems of Care grant is an opportunity to explore how this might look in practice.

19) How should care coordination be evaluated? How should its outcomes be measured?

NQF has a summary of endorsed measures:
http://www.qualityforum.org/News_And_Resources/Endorsement_Summaries/Care_Coordination_Endorsement_Summary.aspx

Should align with the State Innovation Model grant.

Successful connection to services and notification using referral loops to indicate the client participated in referred service.

Measure the care coordination intervention and outcome to assess whether a change in health statues, barrier reduction, etc. are achieved. The care plan or action plan needs to have clearly articulated goals and outcome to ensure the impact is measureable.

Measurements may include overall reduction in disease state or increase in disease management, medication adherence, completion of chronic disease prevention or management program, behavior change, client engagement and activation (many tools exist to measure this), increased quality of transitions of care (care plans created, etc.)

Example outcome measure: Increased # of women identified with pregnancy-related depression receive treatment

For older adult fall prevention, documentation using CPTII codes, and/or G codes that fall risk assessment was completed and falls plan of care was developed and implemented, if needed based on the falls risk assessment.

May consider tying care coordination effectiveness or outcomes to some type of incentive or payment.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

    a. What is the PMPM cost for providing care coordination services?

This depends on what kind of care coordination is being done. For medically or socially complex clients the cost PMPM may be much higher. Tiered systems based on assessment and data may allow a stratification of patients to different levels of care coordination based on need.

For Women's Wellness Connection, the reimbursement is $30 per body part (not per month) for patient navigation and $60 for case management for breast or cervical screening and diagnosis. Both also include the administrative fee.

Medicare will start reimbursing for care coordination at $41.00 PMPM for medically complex patients. There is wide variety.

    b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

    The PMPM should vary by complexity and assessment of need for the individual based on a standard assessment process. Within this context, certain high risk populations may be specially identified as requiring the highest, or lowest, level of care coordination.

    Pregnant women who are accessing the health care system frequently during the 9 months of pregnancy and couple months postpartum likely require a higher intensity of contact and the rate might be too low – would depend on if they are receiving additional services though through one of the more intensive prenatal programs. Infants also need to access the health care system frequently in the first six months of life.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

    Maintaining monthly contact with clients on a face-to-face basis requires a lower caseload (no more than 51-100 clients). If care coordination is primarily by phone and contact is not as frequent a caseload of up to 200-500 might be manageable. This would depend on the client acuity though as well, and again the frequency with which they need to access care. There should be a comprehensive plan in place for the RCCO to receive support If the PMPM or ration is insufficient to provide for the comprehensive care coordination required in contract language.

a. Care coordinator to client ratios. If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

Access to care, preventive care received, referral feedback loop, patient engagement and satisfaction, health outcomes such as emergency department utilization and hospital admissions. (5ee question 19).

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Track and monitor timely completion of recommended health care services and appropriate follow-up. Monitor and track the preventive services that are recommended, and track percentage who are up to date on screening. 5upport the use of health information technology and clinical quality measurement using standard data sources such as NQF Measures (for example to track diabetes or control of hypertension, NQF Measured 59 and 18). Utilizing data to improve clinical processes will positively impact health outcomes.

A component of care coordination is supporting and referring to self-management and disease management programs. CDPHE support evidence-based programs such as the Diabetes Prevention program, the Diabetes 5elf Management and Education Program, the Colorado QuitLine, and home blood pressure monitoring. For older adults, fall prevention programs should be combined or bundled with other chronic disease self-management programs. Reimbursement for evidence-based falls prevention programs should follow the model of chronic disease prevention programs reimbursements.

CDPHE support a medical home approach that maximizes the use of all team members to improve health outcomes for the population served. The inclusion of lay patient navigators, community health workers,

and promotoras to help reduce social and system barriers is essential and will allow licensed and or clinical staff to focus on medically or behaviorally complex clients. Consistent with the Chronic Care Model, clarity of roles and responsibilities, and using the above mentioned roles to focus on barrier reduction, is crucial to the success of team-based care.

Inclusion of coordination with a dental home is essential to ensure the overall health of the client.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Data reporting should be consistent if we are going to understand the impact of the model statewide. Align clinical quality measurement requirements to the CPC initiative as well as the State Innovation Model grant. Support practices in developing capacity to capture and report clinical quality measures at the state level.

Availability or connection to evidence-based chronic disease prevention and management programs across the state rather than relying on each RCCO to develop their own self-management and disease prevention interventions.

Care coordination client identification, risk assessment, and tracking and evaluating should be done consistently across the state so that we can assess impact and outcomes and ensure a standard process in place.

Development of medical neighborhoods and protocols to support access to specialty care should be statewide.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

It is essential that the next iteration of the ACC bolster community-RCCO partnerships and provide structure to support community-based clinical and public health interventions. RCCOs should start by identifying key community stakeholders it already has relationships with, or plans to form relationships with. Key partners include the local public health agencies. RCCOs should have an understanding of the community needs assessment completed in their community and knowledge of public health improvement plans in the various counties that are served. A description of gaps in services in the communities served and which partners are working to address those gaps, if any should also be developed.

a. Partnership with local public health agencies to ensure strong prevention and management programs are promoted. We recommend the following steps to support this community-based partnership:
    i. Require a letter of commitment from all LPHAs within the RCCO geographic region in support of a partnership between the LPHA and the RCCO and clearly identified expected activity:
    ii. The RFP should require that this partnership identify the programmatic or population-based areas of focus that they will focus on. An MOU or business agreement should be strongly encouraged to ensure this partnership has an impact on the population. The following domains of expertise for the LPHAs in Colorado may be considered by the RCCO depending on the needs of the community:

1. Public Education and Health Promotion
2. Population health management, including dissemination of evidence-based programs
3. Outreach and enrollment
4. Data sharing and evaluation

iii. The RCCO/LPHA should also identify performance metrics and an evaluation plan to guide the partnership and provide an opportunity for evaluation and quality improvement.

b. Cultural relevance, including training of health systems staff and plans for addressing activation of clients in specific subgroups (for example, a culturally relevant plan for ensuring African Americans who have the highest rates of cardiovascular disease are actively involved in the prevention and management of their condition.)

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

There is value in identifying the RCCO at a geographic level, as many health conditions are at least, in part, due to physical location (food deserts, rural, specific type of economic disadvantage, etc.) and resources are usually more easily coordinated at a geographic level. Without a compelling argument to support this there does not seem to be an advantage to this approach at this time as it would disrupt the community support and access to local resources.

27) Should the RCCO region maps change? Why or why not? If so, how?

The geographic regions should align across RCCOs and BHOs and consider the LPHA region as well. There should be one system for regionalization of RCCOs, BHOs and public health initiatives. We should align "regional" maps to the extent possible across all services – that may not be possible, but the local communities express frustration over the # of different regions they belong to based on the program. Aligning the BHO and RCCO regions would be a first step – the one who changes should be the one who least aligns with other regional divisions (ex: Health Statistics Regions or LPHA service regions, etc.)

28) Should the BHO region maps change? Why or why not? If so, how?

Yes. See above.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

The current benefits structure provides coverage of preventive services without cost sharing. However there are evidence-based interventions that are not covered thus hindering impact on chronic disease prevention and management. For example, the current benefit structure does not allow for reimbursement of pharmacists, nor does it allow for reimbursement for provision of evidence-based prevention programs like the Diabetes Prevention Program or the Diabetes Self Management and Education program.

Although tobacco cessation is covered there are barriers to maximizing the benefit for Medicaid clients. We recommend removing the Prior Authorization Request requirement. We recommend updating the pharmacotherapy benefit to allow for two covered mediations to be prescribed at the same time per the latest evidence based research. We recommend at least 4 sessions of counseling (at least 10 minutes per session) per quit attempt, and at least two quit attempts per year.

There is lack of clarity around reimbursement for lactation support, including equipment and counseling. The system is very restrictive and women need to access these services immediately in order to maintain breastfeeding.

Breastfeeding/lactation office visits are covered using Evaluation and Management (E±M) procedure codes for problem-specific care. *(The coding isn't cleor for oll conditions for which o boord certified loctotion consultont referrol or pump might be used.)* Most E+M require services to be rendered by a physician, physician assistant, or advanced practice nurse. There are a small number of E±M codes that allow services to be provided by a registered nurse. Lactation consultants are not currently able to enroll as Colorado Medicaid providers. *This is o borrier in thot MDs, Pos, ond APNs ore not typicolly troined in loctotion monogement to the extent of on Internotionol Boord Certified Loctotion Consultonts (IBCLC) - the loctotion expert. This often leods to the wrong pump being ordered which creotes o borrier to breostfeeding.* Manual breast pumps are a covered benefit and do not require prior authorization. Electric breast pumps must be prior authorized."

In order for mom and baby to be successful with breastfeeding they require:

- Timely access to support and equipment *(prior outhorizotion for hospitol grode pumps is not timely)*
- Lactation support often gets included within the hospital fee but mothers report not receiving lactation support. How do we know if the lactation services are happening? While not all families require the lactation expert, community-based IBCLC counseling and support options can be very cost effective but are not currently reimbursed.
- Equipment: The type of breast pump provided is subject to insurers' "reasonable medical management" practices. Medicaid and some plans have opted to provide only manual breast pumps which do not meet all/most women's needs unless truly occasional use.

Recommendation:

- Access: Identify local sources of DME as this will allow quicker access to pumps; large providers are not stocked.
- Approval: Ensure that the onus of decision about the type of pump that is authorized is appropriate and easily accessible. Pump recommendations made by an IBCLC or licensed provider.
- The International Board Certified Lactation Consultant Workforce in Colorado recommendations are 2 IBCLC/1000 births. Colorado has 273 IBCLCs for 65,000 births or approximately 4/1000. Some plans will not reimburse IBCLCs if they are not under a physician.
- Place IBCLCs within the category of "nursing service related providers" and specify the nature of care they provide so they can be reimbursed without being registered nurses.
- Develop a state licensure of lactation consultants.
- Renegotiate hospital contracts so that lactation is reimbursed.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should not be more than one. This would add additional barriers to access for vulnerable populations for whom the system is already complex and difficult to navigate.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

CDPHE supports the strong work that HCPF and the ACC team are doing to promote timely and client-driven attribution. As a regular participant of the PIAC and its' sub-committees we applaud the transparent conversations that lead to meaningful improvement in the program structure. We recognize the importance of attribution and the need to maintain client autonomy and choice. It is especially important to focus on vulnerable or high-risk populations and ensure that they have coverage and access to a provider in a timely manner. Individuals transitioning out of the correctional systems and high-risk pregnant women are two populations that may benefit from active and facilitated attribution , or at least connection to a RCCO care coordinator to ensure that there is a warm hand-off (from Health Communities, the correctional facility, the hospital).

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

The state public health department (CDPHE) has a strong interest in the success and vitality of Colorado's RCCOs and ACC system. This initiative has the promise to advance the conversion of a system that delivers medical care to one that promotes health outcomes throughout the lifespan for all participants. The ACC initiative can do this in a number of ways.

1) Include a representative from CDPHE on the ACC oversight and steering committee (the PIAC and sub-committees. CDPHE Health Systems staff currently attend all committees and could provide a valuable public health perspective.

2) Require RCCOs to connect with CDPHE to discuss ways that state grant funds could be utilized by them to advance chronic disease prevention and promotion activities. CDPHE has three grant funds in particular which can be used to improve the health of Coloradans - The Cancer, Cardiovascular, and Pulmonary Disease Grants Program, the Tobacco Prevention and Education Grants Program, and the Office of Health Equity Grants Program. RCCOs could use these funds to establish systems of care coordination, enlist patient navigators or community health workers in patient care, deploy innovating benefits such as the diabetes prevention program or test a complete range of cessation tools as covered benefits for Medicaid members.

3) Consult with CDPHE to integrate strategies for chronic disease management and prevention from the state's chronic disease state plan. This plan advances several initiatives to build new systems of care and coordination within the health system and strategies to improve the quality of care. It would improve chronic disease prevention and management in Colorado and save the Medicaid program countless dollars if RCCOs looked closely at these strategies and advanced the state's ability to implement them.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

CDPHE supports active collaboration between HCPF and CDHS. Often, RCCOs identify the foster child population as one of the most difficult to provide a comprehensive medical home due to their high needs and geographic instability. We applaud the work that the Systems of Care grant is undertaking. Creating a common fund of braided or blended funding for high risk populations is paramount to improving their experience of care and health outcomes.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

CDPHE applauds the strong collaboration between the ACC and Connect for Health Colorado.

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

With the introduction of new payment methodologies that may require the primary care clinic or system to take on financial risk we recommend close collaboration and communication with the DOI to ensure that sound business decisions are being made that will not negatively impact the provider or the client.

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

- Understand that stakeholder engagement is not uniformed nor static, but rather is a commitment on three distinct levels - the care experience, community level education/involvement and policy development.

- Stakeholder engagement should be reflected in budgets at the state and local level. It is not reasonable to assume that meaningful, consistent and deep stakeholder engagement is a no-cost effort. However, It is an investment that will likely lead to cost savings for the system broadly. (Example: We know that informed and empowered healthcare consumers leads to better system navigation and leads to fewer duplication and lower ER utilization.)

- Stakeholder engagement efforts should include meaningful recruitment and outreach that reflects the community. Evidence based recruitment and outreach strategies such as utilizing Cultural Brokers should be considered. (Similar to peer to peer support and outreach.)

- When Family/Youth Advisors are placed on a committee that meets consistently, compensation should be consistent with industry-standard consultative rates.

- Care Coordination services provided by the RCCO's should be flexible and inclusive to include input and implementation from trained community members (Family Leaders, Parent Navigators) Licensed health professionals, such as licensed nurses, PA's, etc... can be complemented by the systems knowledge held by families and youth who consistently navigate the systems. (Consider the end user as Subject Matter Experts, especially for children and youth with special health care needs.)

- Knowledge and leadership toward successful integration of mental health services.

- Knowledge and leadership for successful care and coordination of children and youth with special health care needs. Refer to the recently published "Standards of Care for Children and Youth with Special Health Care Needs" published by AMCHP and NASHP 2014.

- Training/Integration of concepts and strategies that entail a holistic approach to promoting healthy youth development. These trainings should include:

- youth-adult partnerships to reinforce the connections between caring adults/healthy relationships and positive health outcomes
- a strengths-based and inclusive approach to create and maintain welcoming and youth-friendly environments
- collaborative and sustainable practices that promote and support the integration of a positive youth development approach into the policies and practices of the RCCO's and the clinics they are connected to.

RCCO's should also be engaged in Colorado 9to25 (our statewide youth system that serves all young people across the state) and integrate their best practices into their work (such as youth-engagement standards and working towards a formal Colorado 9to25 endorsement.

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

They should be required to reach out to their LPHAs, family resource centers and early childhood councils to learn about services provided in support of populations health and for targeted populations such as those with multiple chronic conditions, health disparities, pregnant women and young children and youth, especially those with special health care needs, in the community.

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

The local public health agencies could be more intentionally involved in conversations with the ACC and understanding the roles/responsibilities of the RCCOs in their region and exploring how each partner can be mutually contributing and benefiting from the relationship. This can be supported by requiring a more formal relationship between the RCCO and the LPHA. (See question 25)

42) How should the Department structure stakeholder engagement for the ACC as a whole?

We feel that the current ACC PIAC structure provides an opportunity for on-going stakeholder engagement and support continued transparency and inclusion of stakeholders.

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

No.

a. If no, what are the gaps?

Gaps should be systematically assessed by region and provider type.

There are not nearly enough behavioral health providers equipped to manage maternal mental health problems, particularly in rural communities.

Inadequate number of dental specialties for both adults and children, especially oral maxillofacial surgeons, periodontists, endodontists and pediatric dentists.

Not enough lactation experts for the initial assessment within 3-5 days of life.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

Educate dental providers, specialists included, about Medicaid program.

Facilitate provider trainings to expand patient panel to include people with disabilities.

Educate healthcare providers and staff on cultural responsiveness for increased effectiveness in meeting the needs of ethnic/racial and LGBTQI populations with high perceptions of discrimination/distrust of healthcare systems.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

All of the following organizations have a role in developing and implementing older adult fall prevention activities and programs.

a. What role should hospitals play in the next iteration of the ACC Program?

Medical neighborhoods should be developed with the inclusion of hospital and hospital systems. Hospitals should provide real-time notification of admissions and discharges to the RCCOs. Hospitals should

provide linkages to community programs upon discharge or link to the RCCO care coordinator to ensure continuity of care during transitions. Hospitals should be encouraged to utilize their community benefits requirements when developing these RCCO and community partnerships.

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

RCCOs should be required to connect with each of the Local Health Agencies in their Region. RCCOs should be required to submit, as part of their bid, a letter of commitment from a local health agency indicating that they have communicated with that entity, are aware of the local health goals being advanced by that community through the local public health improvement plans and have a plan in place to develop an MOU or BA to advance those community-based improvement goals. (See question 2S) Several health departments have sought funds to implement chronic disease prevention strategies in tobacco, cancer control, obesity control, cardiovascular disease and pulmonary disease. Many of these efforts will be directed toward the same individuals being enrolled by RCCOs. The care received by such individuals would be improved if the efforts being coordinated at the local health agency level were coordinated with the efforts being initiated by the RCCOs bidding for the Medicaid contracts. Additionally, since many of these efforts are being underwritten by state tax dollars, they are fully match able with Federal Medicaid dollars if the state can pursue a state plan amendment with CMS. The more integrated RCCOs with initiatives that use state dollars the larger the Federal match can be.

h. What role should local public health agencies play in the next iteration of the ACC Program? (Please see question 25)

LPHAs that offer direct clinical services (family planning, breast and cervical cancer screening, immunizations) should be a referral source for care of ACC clients.

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

Non-profit primary care clinics that meet the requirement should be part of the RCCO network to serve as a patient centered medical home for ACC clients. Non-profit clinics that do not offer primary care but offer other preventive services (family planning, breast and cervical cancer screening) should be referral sources for clients.

45) How can RCCOs help to support clients and families in making and keeping appointments?

Lay patient navigators can be utilized to support clients and remove barriers to accessing care. Same day appointment availability extended hours, patient portals. Evidence-based client reminder systems can be implemented.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

Yes, BOTH patient navigators and community health workers are essential team members to reduce barriers to care for vulnerable and disparate population and provide culturally competent care.
We would be happy to support the development of a process for including both in the next RFP. We recommend differentiating CHWs from PNs as they are not interchangeable in terms of knowledge, skills and workplace. CHWs are community based, and do not usually interface with health care providers and systems, while PNs reduce barriers to health care access and follow-through, primarily within health systems.

47) **Community Health Worker reimbursement**. Please use the table below to detail how Community Health Workers should be reimbursed:

If you mean patient navigators, they could be on staff at primary care or RCCO or covered by PMPM.

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	X
On staff (salary) at RCCO	X
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

Coordinate with DentaQuest's outreach coordinators to evaluate priority communities lacking dental providers, including specialists. Support DentaQuest and Colorado Dental Association dental provider recruitment efforts. As virtual dental home evolves, support policies that reimburse for Teledentistry services and provide care coordination.

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

For providers, the National Institutes of Health definition: how personal identification, language, thoughts, communications, actions, customs, beliefs, values, and institutions that are often specific to ethnic, racial, religious, geographic, or social groups influence beliefs and belief systems surrounding health, healing, wellness, illness, disease, and delivery of health services. Cultural competency enables providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients.

In the broader context, cultural competence is the lifelong development of skills demonstrated by a set of behaviors, values, and policies enabling an individual or agency/organization to work effectively and inclusively across diverse cultural situations. Criteria for assessing cultural competence include: whether agency board members, staff, interns and volunteers reflect the community to be served; the availability of ongoing professional development for all of the previously mentioned groups: and opportunities for dialog and feedback from culturally diverse clients in the community.

b. What RCCO requirements would ensure cultural competency?

Assess availability of Culturally and Linguistically Appropriate Services (CLAS) standards at points of services. Facilitate support to implement CLAS standards where necessary. Ensure community representation throughout care delivery, management, and leadership process. Include family advocates, peer specialists, community health workers in the team to ensure team-based care is based on connections to the community served.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

See HHS Office of Minority Health's *Think Cultural Health* provider trainings.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Care coordinators, PCMPs and other clinical staff should be required to take either on-line or classroom based cultural competency and low literacy training. The RCCOs could require that print and web materials meet standards for health literacy (reading level, checklists for material view, guidelines for material production) and encourage the use of video and other educational methods such as teach back.

Culturally appropriate care coordination, including recruitment of lay patient navigators, community health workers and/or promotoras from local communities. Note however, that having CHWs or PNs on staff does not replace the need for translation services unless the staff members are certified for translation.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Extended hours, same-day appointments, incentivize to seek appropriate care.

Greater emphasis on preventive services and care, including assessment of preventive service adherence within primary care settings and implementation of evidence-based clinical interventions to increase adherence. This can apply to any USPSTF A/B recommendation, ACIP recommendations.

For older adults a significant part of emergency room fare is due to falls, and an older adult discharged from the ED for a fall is at risk for another fall. RCCOs could be alerted to ED visits and provide care coordination for fall risk assessments, and treatment and referrals (including to community–based fall prevention programs) as needed.

Home-based multi-trigger, multi-component interventions with an environmental focus for children and. Reimbursement for in-home environmental assessments and dissemination of information to Medicaid adolescents with asthma are effective in reducing ED visits, hospital days, ICU admissions and unscheduled Dr. visits clients, health care providers and community health service providers should be supported by the ACC.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	X	☐	☐	☐
Assistance with practice redesign	X	☐	X	X
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices (for older adult fall prevention).	X	☐	☐	X
Provide clinical screening tools	X	☐	X	X
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☐	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☐	☐	☐	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

For screening tools – where these are available and standardized, the RCCO network could help with dissemination and encouraging a standard process. Example for pregnancy-related depression: Edinburgh Postnatal Depression Scale (first choice) or PHQ-9 (second choice). Example for developmental screening in young children: Ages & Stages Questionnaire (ASQ).

For older adult fall prevention, reference the Prevention of Falls in Community-Dwelling Older Adults by the U.S. Preventive Services Task Force (http://www.uspreventiveservicestaskforce.org/uspstf/uspsfalls.htm) and the Updated American Geriatrics Society/British Geriatrics Society Clinical Practice Guideline for Prevention of Falls in Older Persons (http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/prevention_of_falls_summary_of_recommendations)

RCCOs on an ongoing basis should identify and communicate with clients who are coming due or are overdue for age and risk appropriate preventive screenings and immunizations. This reduces the likelihood preventable diseases. Further, Colorado Immunization Information System (CIIS), managed by the Colorado Department of Public Health and Environment, should be the centralized registry that houses all immunization data for RCCO clients and forecasts the immunizations clients are due/coming due for based on the client's age, immunization history and any documented contraindications.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

Clinical guidance has been developed for management of a variety of conditions. Making sure providers know about the evidence-based resource would be helpful. We don't have a mechanism for distributing the guidelines to all providers because we don't have a comprehensive list, but RCCOs do.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

Support new payment models that encourage comprehensive, patient and family centered care, health care value, and improved health outcomes, providing sufficient support to allow practices to transform.

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

For certain disease states and populations, supporting providers in the development of registries is essential.

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

CDPHE supports a transition to value-based payment with provider support to transition. Essential components to support a payment glide path are practice infrastructure support, care coordination payments, and payer alignment. We applaud Colorado Medicaid's efforts to support this. In addition, it is necessary that the support is sufficient to enable true transformation. One of the most difficult transitions for practices is to "between" payment methodologies—expected to perform within a context of value but still reimbursed based on volume. We would recommended (as noted above) a more substantial amount be paid for care coordination. This can be accomplished through a tiered approach that utilizes a care coordination team to provide services and functions along the continuum of care coordination.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

Difficulty with this model is the fact that the cost savings of prevention and appropriate care are often born out within the specialty or hospital payment –how can PCMPs be rewarded for saving outside of primary care setting? What is risk to provider?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Practice transformation, sufficient payment for comprehensive care coordination and payment of non-medical and social services are essential components necessary to accept new payment methodologies. We strongly support the work of SIM and other practice transformation efforts in supporting true transformation.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

CDPHE applauds the transparent process that HCPF uses to determine the KPIs and other potential measures that will be used, such as shared savings. We also support measure alignment with other programs, payers, and initiatives to ensure that undue burden is not being placed on the provider or clinic system. We recognize that even with measurement alignment this is not sufficient to provide a comprehensive picture of outcomes or client and provider engagement and satisfaction.

We strongly support the transition from claims-based measures to those that measure clinical quality and experience of care and recognize that this will require practice support to ensure accurate and actionable data that the provider and payer can trust to act on.

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	X	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	X	☐	
Focus groups	X	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

There are several groups convening to discuss how best to link clinical care and community interventions to measure true population health impact. An important consideration is the dimension of the population under consideration—is the RCCO region considered a population or the entire state? This is necessary in order to start baseline measurement and benchmarking, which will allow targeted clinical and community-based interventions. Population health measures are made more difficult by the fact that many payers who can influence (or help pay for) population health interventions cannot pay for community-based interventions that touch clients not enrolled in their program. True population health should cross payers.

With the current constraints of claims based data, the following are potential measures:

- Many preventive services can be tracked by claims data—at the practice or RCCO level, the population-based measure of preventive services received provides an opportunity to intervene to improve screening and prevention rates. CDPHE has expertise in supporting prevention and screening and could provide technical assistance during the writing of the RFP on how best to capture preventive services as population health measures.
- # of screens completed (Pregnancy-related Depression and & Developmental Screening) – in the case of PRD, the claims data has the ability to tell us if the screen was positive or negative – this would at least tell us if things are being standardized and a more accurate measure of prevalence of depressive symptoms in the population. If the screening code is connected to a behavioral health service code, we could begin to understand if women identified with depressive symptoms are accessing services for treatment.
- Utilization of preventive versus emergency services. Community and family level "hot spotting" of high utilizers.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

Dash-boarding is an effective tool to present complex data in a digestible format. We support transparency if data in a structured process that allows the end users to understand the data and how it impacts their population's health. GIS maps for KPIs and quarterly data reports on access to preventive services versus emergency services may be useful information to provide to the public.

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	X
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs? Yes.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Glide path from improvement to national standards. Need to include comparison to national standards and comparison to other state Medicaid programs to allow an opportunity for benchmarking. This comparison will encourage the RCCO to seek QI interventions to improve their processes and support their PCMPs.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

We support the development of processes to extract real-time clinical data. Focus should be on developing capacity at the practice level to input clinical quality measurement data and extract data for reporting and QI purposes. SIM may help with this. Monthly reporting may be too burdensome unless a data extraction process or connection to HIE can allow seamless reporting. Many practices are still doing manual or custom pulls which may require significant staff time. Progress needs to be made within the context of practice transformation.

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication**. For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	X	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	X
Care management tool	☐	☐	☐	☐	X
Care transitions alerts	☐	☐	☐	☐	X
Electronic Health Records (EHRs)	☐	☐	☐	☐	X
Practice assessment tools	☐	☐	☐	X	☐
Health risk assessment software	☐	☐	☐	☐	X
Practice management tools (scheduling, billing)	☐	☐	☐	☐	X
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	X
Patient education wellness tools	☐	☐	☐	☐	x
Provider/case manager directory	☐	☐	☐	☐	x
Shared decision-making tools	☐	☐	☐	☐	x
Telemedicine	☐	☐	☐	☐	X
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Many providers lack expertise or capacity to fully implement their HIT capacity. CDPHE convened many community leaders and state and national experts on HIT last spring to discuss barriers and opportunities in Colorado. The following subjects were identified:

- Focus on Reliable and Actionable Clinical Data
  During the Health IT Summit, panelists and roundtable participants explained concerns about the reliability of clinical data contained in an EHR. Participants discussed three components to reliable data including inputting data accurately, extracting and analyzing data, and responding to the data. Input and extraction challenges were provided during the Summit, such as an EHR that provided reports on 3,000 year-old people. In addition to concerns about extracting clinical data for reporting and measuring purposes, many attendees also expressed a continued need for system standardization and EHR vendor engagement to improve the process. Providers and participants also explained that with clinical quality measurement reporting requirements, data often is not returned in an actionable format that allows for providers or practices to meet a benchmark or compare their measures to others. During the Summit, an individual remarked that within the federal Meaningful Use program, one missing link is benchmarking which can be a helpful tool in targeting and monitoring improvements within a practice. As a result, some practices may

not see the value nor have the ability to use this data in quality improvement activities. Some attendees recommended increased feedback loops between providers and the organizations requiring clinical quality reporting. Some organizations are able to provide predictive modeling and benchmarking, but this can be cost-prohibitive for smaller practices.

- Support data aggregation and data analytics
  Attendees implementing EHR systems made the case that this effort has created new "data silos" as practitioners and others work to make sense of patients' clinical data within the confines of their own practices. Moreover, there are noticeable gaps in data aggregation and data analytics in the state. Many discussed the need for data aggregation in order to truly understand and measure population health. Recognizing that data aggregation is expensive and difficult, many participants nonetheless expressed interest in a central data hub capable of aggregating and validating clinical data. The RCCOs can provide support to practices and encourage connection to CORHIO as well as engage practices in the State Innovation Model grant opportunities.
- Concentrate on clinical quality measure simplification
  Throughout the Health IT Summit, various stakeholders articulated concerns about misalignment of clinical quality measures across payers and systems. One speaker remarked that with so many measures, it can be difficult for providers to prioritize and target workflow improvements or other quality improvement initiatives. As a result, there are often inefficient and burdensome requirements placed upon providers and health systems staff to report measures to both public and private payers. The Comprehensive Primary Care Initiative, the multi-payer initiative being implemented in more than 70 practices across the state, is an example of the potential for clinical quality measure agreement among payers. There was also a great deal of attention paid to payment reform and the clear connections to clinical quality measurement in helping to inform value-based purchasing of health care. As new payment models are implemented, this could shift behaviors as providers see a greater value proposition in quality measurement, and thus payment reform will help advance health information technology.
- Increase patient engagement
  Patients often are not sufficiently engaged in discussions about quality of care, consumer experience and the ability of consumers to use their own health information data. Participants recommended that patient engagement become an integral component of health information technology for improved care management. Patient engagement and patient portal requirements in Stage Two of Meaningful Use are good steps forward, though the technical infrastructure must be built to make this effort successful. An additional example of improved patient engagement was the inclusion of patient-reported health outcomes.
- Support resource and workforce development:
  One participant remarked that EHRs do not improve care, but the people using EHRs can improve care. Many roundtables discussed the gap between workforce capabilities and expectations within highly sophisticated technological systems. Some participants discussed learning collaboratives as a solution created by multiple practices with the Regional Extension Center partner agencies. The intent of these learning collaboratives has been to develop staff capacity and the potential for providing technical assistance across similar EHR systems. Of course, the amount of financial and staff resources it takes to fully implement, train and maintain health information technology systems can be a major barrier to sustainable implementation. Attendees explained that in rural areas there is a crucial need for hiring knowledgeable health information technology staff because there is often a lack of direct technical assistance from vendors.

There are multiple EHR vendors and the vendors may vary in what fields or assessment packages they provide. For many screening and preventive services, such as older adult fall prevention, if falls risk assessment, treatment option and referrals, including referrals to community-based fall prevention programs, are not included in the vendor package, the clinicians will not b prompted to address this important health care concern.

Providing telehealth services for mental health consultation in areas where there is limited access to maternal mental health expertise would be tremendous. Also, professional mental health consultants who could help a physical health provider in a rural community make accurate and appropriate decisions around medication management would increase the likelihood that a physical health provider would even address a mental health issue.

81) How can Health Information Technology support Behavioral Health Integration?

The adoption of health information technology communication and transport standards are crucial to behavioral health integration. The adoption of these standards will enable interoperability between Health Information Technology systems. In addition, behavioral health integration is dependent on shared data and a single charting system with a shared care plan. Developing infrastructure to support this will be essential for successful integration.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

Yes, we agree that there should be a shared resource for data and analytics. In the next iteration of the ACC, we will rely on advanced analytics to gain important insights from rapidly growing datasets and to make faster, more informed decisions. The platform should be able to efficiently process large volumes of data from diverse sources that is needed to drive these decisions. The shared data and analytics platform should contain the service to provide robust storage and analytics capabilities on semi-structured and unstructured datasets, and allow for integration with other platforms with complex datasets. The platform should be scalable in both performance and capacity, and cost effective over time.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

Shared care management tools are an effective mechanism to ensure effective-real-time sharing of information and data. These tools can support coordination and continuity of care, team-based care, and effective feedback loops for referral. They are difficult to implement across systems due to the barriers with data sharing and perceived HIPAA barriers. The HCPF FBMME demonstration which utilizes a shared care plan will provide important insight on best practice in Colorado. A shared care management and or notification systems is crucial during times of transition. Another consideration is shared care management tool with pharmacies in the community. In order to be useful a care management tool would need to be accessible by all providers, both in clinical and community settings who are working with the individual or family. In addition it would need to clearly delineate the "lead" care coordinator as well as provide real-time information. Other

essential components in order to be useful this tool should identify the patient demographics, how best to contact, patient-centered goals and an action plan on how to achieve these goals. Ideally, the patient assessment with identified barriers to care is included which captures both physical and social barriers.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

Although HCPF has done a tremendous job of identifying providers that accept Medicaid, often the information is incomplete and the provider may have a long waiting list or not accept new patients. A mechanism to update this list so that clients, the Medicaid outreach workers, healthy communities, and RCCO team members are able to refer clients with some confidence that the client will be seen in a timely manner would be tremendously valuable.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

Actionable and timely clinical data, or clinical quality measures, are essential components of a medical home approach. Practices are often required to report clinical data to multiple payers, yet they do not always have the capacity to use this data for benchmarking or quality improvement purposes (see above). The Comprehensive Primary Care initiative and the State Innovation Model grant have provided us with a roadmap to measurement alignment that will provide health information technology support to practices. RCCOs can help support this and provide an opportunity for providers to benchmark their data against other providers serving like populations to prove an opportunity for improvement. For smaller practices this may be more difficult to achieve and they may need practice support and intensive health IT TA to develop the capacity.

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

CDPHE supports the adoption of meaningful use and connectivity to a health information exchange as essential vehicles for improving how we provide clinical care. Additional support can be provided to ensure that practices are able to develop capacity to maximize utilization of their EHR. This will help transform how a practice is able to deliver care and support a true medical home approach to care. HIT can help a provider understand who their patient panel is, develop registries to track screening, preventive services, and disease management, as well as implement point of care decision support, patient portals and secure messaging. Developing capacity to input, extract, report and use data that is accurate and actionable is paramount. In addition, connection to a heath information exchange communication across systems with CORHIO or QHN is essential

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

Technical assistance should be provided along the continuum of health information technology implementation. For those practices without an EHR, they will need vendor support, workforce training, and workflow and process redesign. These are expensive efforts but essential to drive true practice transformation.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

Health Information Exchange (HIE) systems enable providers, hospitals, laboratories and other health care organizations to use approved standards to securely submit clinical information to various health systems and programs. As the ACC requires and adopts standardized electronic reporting, HIE should be the gateway for this electronic data exchange.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 116

Accepted by: KJDW

Notes: Formatting standardized

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: *Banner Health*
Location: *7251 W. 4th St., Greeley, CO 80634*

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Click here to enter text.
Location: City, County, State.
☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: *Hospital, Primary Care, Multispecialty*
  ii. Area of practice: All
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☒ 3-4 years

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Banner Health warks with bath Calarada Access (Regian 2) and Racky Mauntain Health Plan (Regian 1) ta implement the PCMP care delivery madel ta imprave the health af the Medicaid papulatian and decrease the cast af care. We meet manthly with bath RCCOs ta identify and address care delivery appartunities.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Praviding care acrass care cantinuum bath in haspital and ambulatary settings and we're experienced with in athers states with Medicaid managed care and/ar ather fee far service madels.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Banner Health is suppartive af the ACC pragram and will cantinue ta participate. In arder ta ensure the success af the pragram, recammend the fallawing enhancements:
1) Active PCP assignment vs. current attributian

☐ Since before the program was implemented.

model

2) Longer term eligibility periad for Medicoid enrollees vs. manth-to-manth

3) Access ta 100 percent af claims data far all attributed members.

4) Benefit structure to actively steer to PCP rother than ED.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now? *The program has brought health leaders together to identify ways to improve the health and wellbeing of the Medicaid population. We have seen success with some members of that population.*

2) What is not working well in the ACC Program? *The possive ottribution progrom is not working well. It does not creote the necessory olignment between the PCP ond the member. The inobility to shore potient dota due to risk of PHI liobility. Current benefit structure does not support member engagement ond accountability.*

3) What is working best in the Behavioral Health Organization (BHO) system right now? *Having co-located traditional therapist with PCP has improved number of Medicaid patients receiving mental health services and better treatment initiation and compliance than before co-located therapy started.*

4) What is not working well in the BHO system? *The BHO is doing traditional therapy and not truly integrated care with PCP. It would be preferential to have integrated care where BHO supports a model of care in which therapy is integrated into routine office visits and access to Electronic Medical Record (EHR) that the clinic uses. There is a disconnect of documentation and care.*

5) What is working well with RCCO and BHO collaboration right now? *The local "hot spotter" groups allow for networking of all care disciplines in one place at one time to discuss high cost utilizers and potients with unique care coordination problems. This occurs twice a month and de-identified potients are discussed.*

6) What is not working well with RCCO and BHO collaboration right now? *Lack of information transmission between BHO and primary core offices.*

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1] *We need to break silos and integrate behavioral health into the medical treatment arena. We need to eliminate barriers that result in fragmentation (ie state laws, HCPF departmental structure, reimbursement, sharing data).*

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	By creating separate financing, this continues to encourage silo mentality.
Community Behavioral Health Services Rule	☒	☐	Multiple and conflicting roles only add to fragmentation of payment and services
Covered diagnoses list	☒	☐	List is too exclusive, marital conflict not billable, certain abuse diagnosis not billable, substance abuse as primary diagnosis is not billable, no "V" codes are billable.
Different behavioral / physical health reimbursement	☒	☐	Management of behavioral health needs to be part of the overall health plan for the patient. Separating the reimbursement continue to fragment the care
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	Separate OBH oversight only adds to the fragmentation between individuals physical and behavioral health needs. Ideally oversight and rules would be structured to look across the entire care continuum (consistent with the health model vision articulated for the next RCCO)
PCMP financing structure	☐	☒	
Per-member per-month amount	☐	☒	
Physical space constraints	☒	☐	Not all clinics would have a space available for a mental health provider, and volume of patients may not support a full time mental health specialist on clinic site
Privacy Laws (HIPAA, 42 CFR)	☒	☐	We have to create a balance between protecting PHI while supporting active care coordination across the care continuum.
Professional / cultural divisions	☒	☐	Silos created due to financial structure.

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

RCCO or BHO contracts	☒	☐	All members of the RCCO should have the same contracts with BHO for true integration
Staff capacity	☒	☐	Scheduling and admin employees of PCP and BHO currently not able to share information between each other for non-clinical and non-counseling purposes
State/Federal rules or reporting requirements	☒	☐	No consistency for information sharing. Disparity for substance abuse treatment, State deals with mental health and Federal is substance abuse diagnosis
Technical resources / data sharing	☒	☐	Addressing privacy laws that restrict care (ie State provide a waiver for sharing PHI to improve integration and care within non-clinical teams to help address economic or social issues that may be contributing to the medial/behavioral conditions)
Training	☒	☐	To establish agreement on the common goals and objectives on the population.
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

Having therapist that are team based, free infarmatian sharing, caardinated treatment plans between PCP and therapist, documenting mental health in the PCP medical recard, ability far PCP ta see mental health diagnasis and care plan, but nat therapy nates ta ensure care caardinatian.

10) Please share any other general advice or suggestians you may have abaut behavioral health integratian.

Behaviaral health praviders need ta be campensated far integrated care. Currently na mechanism far billing when therapist sees patient with PCP far care caardinatian, discussian af treatment gaals, etc. Only traditianal psychatherapy is billable event.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination? *Actively plonning ond onticipoting potentiol ond octual barriers in moving patients through the care continuum.*

b. How should RCCOs prioritize who receives care coordination first? *First driver should be high utilizers ond the second should be potients in the highest risk stroto bosed on multiple co-morbid conditions.*

c. How should RCCOs identify clients and families who need care coordination? *Will find that in yaur high utilizers. Cultural behaviors taught within families.*

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider? *It should be trocked consistently ocross the stote bosed on outcomes. It should o set target rather than a rate of improvement.*

12) What services should be coordinated and are there services that should not be a part of care coordination? *If it's o borrier, it needs to be coordinoted (ie tronspirotion, sociol, behoviorol heolth, economic issues).*

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs? *Need to know their sociol economic stotus, how mony dependents, ond if there is o known behoviorol component.*

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today? *Care coordination occurring at Dept. of Social Services area (protecting child and protective adult); case managers that are embedded in community to address financial and social issues; case managers with within the school system; case managers for impaired adults; case managers embedded in the physicians' offices.*

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different? *School system, county level, ot-risk adult populotion. Differences: These hove occess to voucher progroms within the stote Medicaid system that can increose resources for these patients.*

c. How can the ACC avoid duplicating or disrupting current care coordination relationships? *Core coordinotion relotionships must be centrolly coordinated. Who needs to house ond mointoin thot informotion? Need o centrolized depository.*

d. What are the gaps in care coordination across the continuum of care? *Data, issue with behaviaral health and privacy, issue of na farmal chain of cannectivity far coardinatars thraughaut cammunity system.*

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	Should the RCCO have a role? No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☒	
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	
Daycare / childcare	☐	☒	☒	
Economic stability & employment	☐	☒	☒	
Education	☒	☐	☒	
Environment	☐	☒	☒	
Food access / nutrition	☐	☒	☒	

Health literacy	☐	☒	☒	
Housing	☐	☒	☒	
Language or translation services	☒	☐	☒	
Literacy	☒	☐	☒	
Transportation	☒	☐	☒	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	
Certified Addiction Councilors	☒	☐	
Certified Nurse Midwives	☒	☐	
Community Health Workers	☒	☐	
Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☒	☐	
Licensed Mental Health Counselors	☒	☐	
Licensed Professional Counselor	☒	☐	
Masters of Public Health	☐	☒	
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	

Nurse Practitioners	☒	☐	
Patient Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☒	☐	
Psychiatrists	☒	☐	
Psychologists	☒	☐	
Registered Nurses	☒	☐	
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☐	Specialty care for pre-term and high-risk infants.
Children	☒	☐	Specialty care for children with high-risk conditions or high needs.
Children who are healthy, but in socially-complex environments	☐	☒	
Children involved in the foster care system	☐	☒	
Children with a chronic illness	☒	☐	specialty pathways to coordinate with pediatric specialists
Children with a serious emotional disturbance	☒	☐	Specialty care for children with high-risk conditions or high needs.
Children with medical complexity	☒	☐	Specialty care for children with high-risk conditions or high needs.
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	Specialty care for children with high-risk conditions or high needs.
Transition-age adolescents	☐	☒	
Parents and families	☐	☒	
Pregnant women	☒	☐	specialty care for high-risk specialty
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☐	☒	

Adults with a chronic illness	☒	☐	Specialty care for adults with high-risk conditions or needs.
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	specialty care for adults with high-risk conditions
Clients involved in the criminal justice system	☐	☒	
Clients with a disability	☒	☐	specialty care for adults with high-risk conditions
Clients in a nursing facility	☐	☒	
Elderly clients	☐	☒	
Frail elderly clients	☒	☐	specialty care for adults with high-risk conditions
Clients in palliative care	☒	☐	specialty care for adults with high-risk conditions
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

Integroted care and registries of foster children to query for at minimum annual well visits or more frequently based on medical and mental health issues. Medicolly complex would be the same but with registry according to a chronic diagnosis – would likely need to qualify what diagnosis groups would be included in this type registry. Social complexity would be more difficult to stratify – this is a very broad group/statement. Would suggest o unique identifier as part of their Medicaid number that would make these types of patients easily identifiable without access to their medicol records.

19) How should care coordination be evaluated? How should its outcomes be measured?

Benchmorks according to diognosis – depression would be improvement in PHQ9 or A scores, diobetes would be improvement of HgbA1c, etc. Also on improvement of potient's perception of their diognosis or chronic illness or improvement in self monogement skills ond obility to occess community resources.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services? *$4-5 depending on scope of services ie, behoviorol heolth, educotion ond phormocy.*

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population? *Risk strotificotion model similor to Medicore tied to PMPM distributions would more occurotely tie reimbursements to core of the populotion.*

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population? *No.*

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important? *Utilizotion – ED, Reodmission Rotes ond overoll cost of core*

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies). *Core coordinotion requirements.*

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs? *The bidder needs to reside in the community where it wishes to provide services. Connot odequotely do so as on outside resource.*

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal. *It might be helpful only if there is o specialized need for core monagement thot expertise moy be in one region and not onother, otherwise* ***probobly not o good ideo.***

27) Should the RCCO region maps change? Why or why not? If so, how? *Yes, the medicol communities between Larimer ond Weld counties routinely work closely to monoge populotians and while the RCCOs in Regions 1 ond 2 work well together, would suggest these two counties be in the some regions.*

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition? *18 months. 6 months to estoblish boseline doto, 12 full months to estoblish o trend of improvement.*

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective? *Removing borriers to integroted core with informotion shoring ond occess to clinic EHR for BHO employees thot ore co-monoging one potient.*

31) What are the limitations of the current benefit structure and what – if any – changes are needed? *In current benefit structure, no steeroge to finoncially encouroge members to occess lower cost levels of care before occessing higher costs of core. Would recommend chonges in the financiol steeroge structure. For*

exomple no incentive to see PCP for non-urgent or emergent medicol conditions, octuolly cheoper ond more convenient to go to Urgent Core or ER for services. $2 copoy ot PCP office ond no copoy ot ER!

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address? *No. One of the chollenges with this potient populotion, is they move from provider to provider so odding RCCO ployer would increose confusion with coring for torgeted populotion.*

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not? *N/A*

34) What role should RCCOs play in attributing clients to their respective PCMPs? *The RCCOs should be empowered and allowed to work with the medical communities and PCMPs (that are accepting new clients) to assign clients that ore unattributed..*

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment? *Direct communicotion to the ACC when patients have repartable conditions that have not been treated yet would be helpful. Would this be the entity that could build and maintain registries that could be queried by PCMPs for different medical or behavioral health conditions for care monagement and follow-up purposes?*

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services? *Again accessible registry for at risk individuals. It would also be great to be able to report as a mandatory report through an electronic medium rather than placing phone calls and waiting for return phone calls.*

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado? *The obility for providers/hospitols to know if o potient hos up to dote insuronce – "poid to dote" visible. Heolth core providers ore ot risk for providing services ond procedures to potients thot hove not poid their premiums but it is not visible to these providers.*

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates? *Transparency to all enrolled patients of what case management services are available in their region's RCCO and outcomes reporting on KPIs. Disclosure and capture of all stakeholder demographic information and release of privacy liability if sharing PHI to stakeholders.*

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region? *The same as above. More training to community organizations, social service providers and other care professionals in the region on exactly what RCCO is, and what their services are in their region and other regions of the state if they differ.*

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC? *More frequent outreach perhaps in the form of public service announcements, television and radio time, newspaper articles about what RCCO is and who they serve.*

42) How should the Department structure stakeholder engagement for the ACC as a whole? *Active assignment of the client to the PCP and develop material that stresses the importance to coordinate all care through the PCMP.*

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population? *No*

a. If no, what are the gaps? *Behavioral health and dental care are very lacking in numbers af praviders campared ta numbers af patients needing these services. Specialists are less likely ta take Medicaid papulatian if nat farmally referred by a PCP.*

b. Please address gaps far the papulation as a whale, and far specific subpopulatians such as children/families and individuals with disabilities. *Children af all ages with PT, OT and speech therapy needs can't get enaugh services. Elderly and disable have prablems with medical transpartatian if they can't drive and dan't have family that can drive (significant issue that results in delayed care and higher ED utilizatian). Childcare services far patients during their medical ar mental health visits ar graup visits.*

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program? *Co-locoted ER ond Urgent cores in focilities when spoce ollows to more appropriately trioge high cost vs low cost medicol visits.*

b. What role should pharmacies play in the next iteration of the ACC Program? *More options for delivery of medications for potients with tronsportotion problems (significont issue). The obility to repart to PCP medicotions written/dispensed from other providers including poin medicotions. Foster ovoilobility of utilizotion ond fill doto on prescriptions. It needs to be ovoilable in on eosily query such os the PDMP dotobose of opioids.*

c. What role should specialists play in the next iteration of the ACC Program? *Tronsporency from specialties an who tokes Medicoid ond how mony potients per month or percentoge of ponel they will occept in their proctices.*

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program? *Increased funding for CCBs and more availability of day programs and workshops for disabled patients and developmentally disabled patients. Increase the number of single entry points*

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? *Are there potential partnerships with these organizations which have been overlooked in the past? Educational programs for patients and for communities on diseases, community resources, integrated core principles, partnerships for funding for indoor exercise facilities in every community – not fancy, but a place to safely walk.*

45) How can RCCOs help to support clients and families in making and keeping appointments? *Provide transportation when needed and reminder calls and text messages. Accountability that is enforceable for patients that willingly don't show up for appointments.*

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP? *No, it should be up to the individual RCCO according to community need.*

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐

On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☒

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you? *The knowledge of potients belief systems regarding ethnicity, religion, fomily, medical beliefs, heolth norms, etc. Not oll culturol issues ore religious or ethnicolly bosed.*

b. What RCCO requirements would ensure cultural competency? *Online or print educotion regording the most common cultures thot certoin communities encounter.*

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy? *Understand what is the mast predaminant culture in that cammunity – staff should just have a gaad resaurce available to study/cansult with when encauntering a new culture ar language. Interpreter services shauld be in every clinic if nat already. Health Literacy evaluotians shauld be dane annually but nat anly ot a pravider's affice, this could be thraugh ACC enrollment and re-enrallment os part af their intakes.*

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes? *Providing eosy to odminister literocy tools ond troinings to clinics ond community providers.*

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care? *No. It again causes more fragmentation.*

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend? *Copoyments ot time of ER if not odmitted, ond these should be higher thon copoyments to see their PCP. This would moke non-emergent ER visits less utilized*.

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals. *Reimbursement for oll ospects of integroted core*.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☒	☐	☐	☐
Provide practice-specific data reports	☒	☐	☐	☐
Provide clinical care guidelines and best practices.	☒	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☒	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☒	☐	☒	☒
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☒	☐	☐	☐
Supply other self-screening tools	☒	☐	☐	☐
Administer behavioral health surveys	☒	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☒	☐	☐	☐
Provide comprehensive directory of community resources	☒	☐	☒	☒
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☒	☒
Others	*Seomless ond comprehensive tronsportotion for follow-up core, phormocy, etc.*			

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes? *Improved and rapid access to claims data and prescription utilization data.*

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home? *Additional funding for PCMPs specifically to support patient registry.*

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population? Yes if integrated and interoperable with PCMPs EMR. *No. A lot of systems have built and are using registries already, to mandate them could negatively impact their existing workflows – they would be great to be able to access but not "mandated".*

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals? *No. Some of the KPIs from last year were negatively impacted to enrollment of new members. For example, many new patients were enrolled in Medicaid in our region, and they did not have a medical home, but went to ER for services and imaging, negatively affecting our KPI performonce.*

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation? *There is interest in exploring PCMP capitation with the requirement that clients are assigned to a PCMP and benefits are structured that all care is directed by the PCMP and there is on overoll shared sovings if PCMP is successful.*

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure? *Pay for performance is more likely to be bosed on potient's willingness and ability to self monage their problems. It should not negatively affect reimbursement for providers when potients ore unwilling to be part of their care teom.*

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes? *Meosures should include potient complionce os well os provider use of evidence bosed proctices. Not meeting quolity meosures does not*

mean praviders are not daing their jabs appraprіately; it needs ta be evoluoted fram patient compliance perspective as well.

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☒	
SF-12 Health Survey	☐	☒	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☒	☐	
Focus groups	☒	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured? *Build registries with health care recommendations by age and gender for query. If services were performed at different entity, the date and name of entity should be in the registry for record retrieval from current PCP or provider's office.*

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public? *Availability an internet through state website.*

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐

None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☒
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs? *No*.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement? No. Many patients will not show improvement even through their quality of life may be better and their disease more stable.

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures. *No*

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures? *Monitoring registries of ER visits, hospitol odmission ond dischorge doto for core coordinotion needs ond office follow-up needs. Registries of chronic illnesses including depression for follow-up core, pre-visit counseling, obtoining lobs before oppointment with providers. Depression screening ond referrol to on site mentol heolth speciolists for counseling services when identified ond potients ore willing. Monitoring potient sotisfoction through Heolthstreom telephone surveys.*

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☒
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☐	☒
Smartphone app	☐	☒
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☐	☒
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☒
Telemedicine software	☒	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☒	☐	☐
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☒	☐	☐
Health risk assessment software	☐	☐	☒	☐	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☒	☐	☐
Patient education wellness tools	☐	☐	☐	☒	☐
Provider/case manager directory	☐	☐	☐	☒	☐
Shared decision-making tools	☐	☐	☐	☒	☐
Telemedicine	☒	☐	☒	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices? *Problems finding claims data for services provided elsewhere, slow EHR that prevents providers from utilizing data reol time during affice visits in many cases, difficulty having reports built for population monagement, excessive time needed to appropriately docment in current EHR for meaningful use and PCMH documentation requirements.*

81) How can Health Information Technology support Behavioral Health Integration? *One EHR. Need to have all of a patient's care and diagnosis relevant to their care visible to behavioral health AND medical providers. Mental health diagnosis and medications as well as substance abuse issues often change how care is provided, what medications are prescribed, and how much care coordination is needed.*

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? *Yes.* Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful. *Procedure ond medicotion claims ond utilization doto including the performing or filling entity,*

diagnosis codes, visit reosons, locations ond dotes, immunization dato or link to CIIS, listings of all praviders the potient hos seen in state or out of state.

83) Should there be a shared care management tool? No. Without standard EHR platform it would require double documentation for providers, and they don't have time to do this. Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

84) Should there be a shared population health management tool? No. Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful. *Percentoge or number of Medicoid/Medicore potients ollowed in proctice, oll services offered by eoch of the providers, hours of aperotion, credentials*

86) How can the RCCOs support providers' access to actionable and timely clinical data? *Cloims doto is toa old to be meoningful in most circumstonces. Admission ond discharge notificotions and ER utilization is needed for clinics to core coordinote within 24 haurs of o visit, not 3 months later. A woy to notify the PCMP thot a potient hos been in a facility in o timely bosis. Also notificotian for PCP of potient visit to any other facility thot is not their PCMP clinic.*

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used. *This would be difficult given that many different base EHR and scheduling/billing systems exist. Asking clinics and praviders to dacument or review other portals adds another layer of IT frustratian that may not impact autcames or care very well.*

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program. *Any HIT thot moy be deemed necessory should be developed in colloborotion with the end users before ond ofter development ond implementotion. Engineers ond providers don't think olike. Insuronce ond cloims needs ore different from query ond documentotion needs in clinics.*

Colorado Department of
Health Care Policy and Financing

Serial #117

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Kristen Dixion, MA,LPC & Jacquelyn Cully
Location: 3738 W Princeton Circle Denver, CO 80236

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: University of Colorado-Denver Addiction Research and Treatment Services (ARTS)
Location: 3738 W Princeton Circle Denver, CO 80236

☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

- ☐ Client
- ☐ Client's family member
- ☐ Client advocate
- ☐ Medical provider / PCMP / other provider
  - i. Type or specialty:
  - ii. Area of practice:
- ☐ Provider advocate (e.g. medical society)
- ☐ Potential bidder for RCCO contract
- ☐ Behavioral Health Organization
- ☐ Data or HIT entity
- ☐ Foundation
- ☐ Educational or research institution
- ☐ Another public or private program
- ☐ Legislator or elected official
- ☒ Other (please describe): Provider of co-occurring substance use and mental health disorders. *It would be helpful if the Department identified behavioral health providers as a discrete provider type, instead of "other."

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Patients who are enrolled in a RCCO and BHO have significant difficulty getting their BHO benefits covered. Their claims are repeatedly denied as "bill to RCCO." RCCO denies claims as bill to MCO.Neither have been able to provide an adequate solution for these patient

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

ARTS provides weekly feedback to contracted BHOs in order to assist with claims processing. The BHOs all struggle with processing claims for patients who have dual diagnoses

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

- ☒ Very likely
- ☐ Likely
- ☐ Reserved (waiting to see the RFP)
- ☐ Unlikely without significant changes
- ☐ Will not seek to participate
- ☐ N/A

Are you currently involved in the ACC program?

- ☒ Yes ARTS is a contracted BHO provider and by delegation of our responsibilities under the BHO system, we ars indirectly involved with the ACC program. Unfortunately, substance use disorder providers sre not represented to the ACC in the same way as PCMPs or specialty medical providers.
- ☐ No
- ☐ I don't know

If you answered "yes" above, how long?

- ☐ Less than one year
- ☐ 1-2 years
- ☒ 2-3 years
- ☐ 3-4 years
- ☐ Since before the program was implemented.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

The ACC has helped all providers impetus to coordinate behavioral health and primary care services for improved health outcomes and adherence to treatment objectives. The Department's outreach to organizations like COPA (CO Provider's Association). The Department's willingness to listen to providers when code set issues arise.

2) What is not working well in the ACC Program?

(1) ARTS Billing Department must hire more staff to meet the work demands of Medicaid billing. It is time consuming and fraught with denials due to the misunderstanding of how substance use disorder treatment and services are delivered. ARTS has to hire more billing staff to follow-up on denials, partial payments, authorizations and re-authorizations. This was a significant unforeseen problem with Medicaid expansion.

(2) The BHO's all operate independently and it is challenging to navigate these new systems in order to get reimbursed for services. There are services that ARTS has not been reimbursed for since January 2014. This is unacceptable. Substance use disorder treatment is an underfunded system and the populations we serve are in great need of behavioral health services. Providers do not have the resources to continue to provide services while waiting for reimbursements and covering costs that are not reimbursable based on the appropriate delivery of substance use disorder services.

(3) There is a significant workforce development issue due to the disparity in the reimbursement rates for the Medicaid behavioral health benefit. Substance use disorder programs are licensed by OBH and credentialed by other governing entities and identify CAC's as an essential and required component to SUD treatment. CAC's have been providing effective SUD services for many years and SUD programs' infrastructure reflects this. CAC's have specialty addictions training and are crucial to our programs; however, their services are reimbursed at at lesser rate than a LPC or LCSW. This is a significant problem. Based on the current Medicaid credentialing requirements, substance use disorder providers will need to hire higher level staff (i.e., LCSW, LPC, etc.). This is a huge cost to providers and changes the SUD infrastructure dramatically.

Additionally, there is a lot of focus on recovery based services and well as recovery models and the benefits they have for individuals with substance use disorders. ARTS has staff that are in recovery and have the necessary credentials to provide excellent substance use disorder treatment (i.e., Certified Addiction Counselor - CAC). These counselors have a wealth of knowledge and experience and are tremendously effective with others that are working towards or in recovery. However, it is difficult to find higher credentialed staff with recovery experience. This area of disparity needs further exploration and discussion.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

The BHOs are doing as much as they can to create greater access to care for substance abuse patients. Patients with dual mental health and behavioral health diagnoses often have to attain a prior authorization, when in the past prior auths were not required

4) What is not working well in the BHO system?

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

The BHOs seem to have issues with the merger of the SUD and BH code sets. There are issues with the way that claims have to reflect different diagnoses based on which code set you are billing.
BH providers are still narrowly restricted to billing either the SUD code set or BH code set.
Some BHOs require prior authorization for care that is routinely provided, such as MAT in an OMAT clinic.

In section 1.4.1.2.2. you requested input on "how the BHO or RCCO maps or functions could be adjusted to create better alignment," and the issues in order of primacy are:
(1) "Integration" customarily means that behavioral health services are being included in a primary care delivery model. The Department's use of the word "integration" to describe their objective of coordinated physical and behavioral health is appropriate; however, this objective does not resonate with patients who have already decided which provider types they need to establish care with based on their most pressing health needs. The majority of our patients fail to establish care with a PCP, and patients cannot access PCPs and CMHC services in a timely manner. How will the Department assist patients with establishing care with a PCP?
(2) How will the different behavioral health provider types integrate with each other? When a patient is referred and care is established, will there be input from behavioral health providers on the minimum documentation that is necessary? Does the Department have a method for implementing shared documentation for care management? If by "integrated" the Department means that all Medicaid patients will receive their referrals for behavioral health services from their PCMP, and CMHCs will refer patients to more specialized behavioral health treatment, then that system does not appear to be working. The way the integration is working for patients at ARTS is as follows: (1) Patients make contact with the provider who treats their most pressing health needs; (2) patients who need psychiatric services are referred to CMHCs, but are waiting on average 11-14 days before their first treatment contact and some patients have reported waiting 43 days; 3) Medicaid patients experience on average greater exposure to endemic poverty, lack of resources, and less motivation to attain a PCP in the RCCO system until they have a serious health event.
(3) In section 1.4.1.2.3. the Department proposes developing treatment objectives specific to the different Medicaid "subpopulations" (children, adults, elderly, those involved in the criminal justice system). Will the delineations for subpopulations include the criteria for priority populations? The priority populations established by Signal MSO and OBH, are IDU, pregnant women with substance abuse issues, adolescent IDU,..... Signal MSO provides indigent funding for priority population patients who are without insurance or insurance has refused to cover their behavioral health services. It would seem appropriate for the Department to incorporate the established priority populations. Will the treatment objectives for each population be established by the Department or the BHOs? Will the Department implement a uniform practice amongst all RCCO providers that elevates/expedites the treatment for priority populations?
(4) In the RFI there was little mention of the Departments efforts to collect data relevant to the parity imperative. What efforts will be made to counteract the ongoing financial behavior that marginalizes certain types of treatment, namely substance abuse disorder?
(5) The special connections population is Will the MSO's (Signal) be responsible for providing OBH with DACODS data in timelier manner? Providers are only able to be reimbursed for services provided to the Special Connections population when OBH receives demographic data from DACODS. The administrative efficiency will need to be addressed regarding this issue as it is directly related to the treatment of priority populations.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	CMHCs are provided a per member per month rate, but other providers who support entire Medicaid populations are not provided this rate. The CMHCs have been slow to respond to the growing needs and demands of the burgeoning Medicaid population.
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☒	☐	What will be the mechanisms to ensure parity?
Institutions for Mental Diseases exclusion	☐	☒	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	This is a significant barrier. Departments have misunderstandings about the impact of ACC on providers. There are also conflicting policies.
PCMP financing structure	☐	☐	
Per-member per-month amount	☒	☐	
Physical space constraints	☒	☐	
Privacy Laws (HIPAA, 42 CFR)	☑	☐	This is complicated and a solution needs to be identified.
Professional / cultural divisions	☐	☒	
RCCO or BHO contracts	☒	☐	
Staff capacity	☒	☐	
State/Federal rules or reporting requirements	☒	☐	
Technical resources / data sharing	☒	☐	
Training	☑	☐	
Others	Please type your response here.		

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

b. How should RCCOs prioritize who receives care coordination first?

c. How should RCCOs identify clients and families who need care coordination?

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☒	☐	☐	
Daycare / childcare	☐	☒	☐	
Economic stability & employment	☒	☐	☐	
Education	☐	☒	☐	
Environment	☒	☐	☐	
Food access / nutrition	☒	☐	☐	
Health literacy	☒	☐	☐	
Housing	☐	☒	☐	
Language or translation services	☒	☐	☐	
Literacy	☒	☐	☐	
Transportation	☒	☐	☐	
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☐	☐	
Certified Addiction Councilors	☐	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☐	☐	
Generalists (BA/BS/MA/MS)	☐	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☐	☐	
Licensed Marriage and Family Therapist	☐	☐	
Licensed Mental Health Counselors	☐	☐	
Licensed Professional Counselor	☐	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☐	☐	
Nurse Practitioners	☐	☐	
Patient Navigators	☒	☐	
Peer Advocates	☐	☐	
Promotoras	☐	☐	
Psychiatrists	☐	☐	
Psychologists	☐	☐	
Registered Nurses	☒	☐	
Social Workers	☐	☐	
Wraparound facilitators	☒	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations**. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☐	☐	
Children	☐	☐	
Children who are healthy, but in socially-complex environments	☐	☐	
Children involved in the foster care system	☐	☐	
Children with a chronic illness	☐	☐	
Children with a serious emotional disturbance	☐	☐	
Children with medical complexity	☐	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	
Transition-age adolescents	☒	☐	
Parents and families	☐	☐	
Pregnant women	☐	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☒	☐	
Adults with a chronic illness	☐	☐	
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	
Clients involved in the criminal justice system	☒	☐	
Clients with a disability	☐	☐	
Clients in a nursing facility	☐	☐	
Elderly clients	☐	☐	
Frail elderly clients	☐	☐	
Clients in palliative care	☐	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Encounter data from CMHCs inform the Medicaid covered code set. Encounter data are also used by OBH to get reimbursed based on CCAR data and client level service data. These data are also used for OBH's C-Stat engagement measure (4 services in 45 days). SUD providers need access to a more expansive code set to accurately reflect their scope of services. The per client payment that FQHCs and CMHCs receive put specialty providers at great risk. SUD provider data is not included throughout the service level data utilized by the Department.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

(1) Analysis of treatment needs which includes input from providers of each treatment modality.
(2) Assign a provider liaison based on patient volume
(3) Do not overlook SUD providers

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal. N/A

27) Should the RCCO region maps change? Why or why not? If so, how?

The RCCO maps need to be illustrated with a more legible font and the coloration of the different regions needs to be far more distinctive. It is impossible to use the RCCO map to educate other staff or patients.

28) Should the BHO region maps change? Why or why not? If so, how?

It is not as easy to find a BHO region map, so it would be helpful if it were made more available on the Department's website.

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

Expenses: The cost to the provider will be most dependent upon the volume of patients served, and the need for continuous care. Substance use disorders are chronic diseases that require continuous support. Providers have to hire care coordinators or peer specialists to assist patients with establishing care with a PCMP.

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

SUD providers should be allowed to provide pharmacologic therapies with the medications SAMHSA has identified as part of the Medication Assisted Treatment modality. Currently, only Methadone is covered in an OMAT clinic, and that leaves the population of SUD patients with fragmented treatment options. OMAT providers are federally accredited by SAMHSA and state licensed by OBH implement the most efficient and evidence-based methods for MAT. Since SUD providers have been overlooked, our cost-efficiencies have been overlooked.

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

For SUD providers, the code set remains limited. For example, code S9445 for urinalysis (U/A) is only reimbursable for the completion of three distinct services: (1) the collection of the sample, which has to be monitored by staff; (2) the analysis of the sample itself, which requires that the provider contract with a lab service and pay for the packaging and delivery of the sample; and (3) the review of the results with the patient lasting 15 mins (or >8.5 mins), which is most appropriately done in the patient's individual counseling session, but does not reimburse at the same rate as a 15 min counseling session. The code S9445 reimburses around $13.50, and the provider's cost of providing this service is around $18. U/A monitoring is mandated by OBH and SAMHSA. All other codes in the BHO contracts that require a compound service including delivering a test and interpreting the results with the patient, like 96116 or 96118, reimburse at a much higher level ($78-$150) and other types of providers have access to a code specifically for the interpretation of test results, 90887, which reimburses at $40 per encounter. SUD providers are at a disadvantage.

Will the department start advocating for Medicaid coverage for patients who are in residential/inpatient substance use disorder treatment?
ARTS' Peer I, substance use disorder residential treatment program has high success rates, low relapse rates, and yet are still considered part of the same treatment domain, that is community corrections, as halfway houses. Halfway houses do not provide treatment. These patients are involved in the criminal justice community, which the Department highlighted as a subpopulation with unique needs. There needs to be a policy change related to "inmate status" to allow these individuals to be eligible for Medicaid.

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not? N/A

34) What role should RCCOs play in attributing clients to their respective PCMPs?
RCCOs should employ care-coordinators that specialize in the different patient populations so that SUD clients who struggle with establishing care are treated with greater sensitivity to their treatment needs.

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?
Signal, OBH, and the BHOs all require data reporting on evidence-based practices, encounter data, access data, and data on priority populations and any duplication should be eliminated.
The ACC should work with OMAT clinics who employ addiction medicine doctors who are more well-versed in the administration of pharmacological therapies for MAT.

37) What types of collaboration should exist between the ACC Program and the Insurance marketplace / Connect for Health Colorado? N/A

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance? N/A

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

It is imperative to expand evidence-based and promising practices coverage. The following are potential areas of Medicaid benefit expansion that could bridge specific gaps:

- Adolescent SUD treatment and home-based treatment (i.e. multi-systemic family therapy) is identified by SAMHSA as one of the most successful evidenced-based practices for the treatment of co-occurring disorders but are largely underfunded based on current rates.
- The provision of services under ACT and ACRA treatment models should be available to both adults and adolescents with co-occurring disorders.
- In Colorado, the services provided by doula's are not reimbursed. There is a lot of research on the benefits of the integration of doula care and residential SUD women.
- The utilization of therapeutic communities for pregnant women struggling with SUD.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program? N/A

b. What role should pharmacies play in the next iteration of the ACC Program?
340 B pricing should be a priority.

c. What role should specialists play in the next iteration of the ACC Program?
Specialists like SUD providers, like ARTS, have not been able to provide input.
MAT services and outpatient SUD services for co-occurring disorders for adolescents and adults are most cost effective when provided in specialty SUD clinics, and least cost-effective when provided by unspecialized mental health providers.

d. What role should home health play in the next iteration of the ACC Program?
N/A

e. What role should hospice care play in the next iteration of the ACC Program?
N/A

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?
SUD providers should be included.

g. What role should counties play in the next iteration of the ACC Program?
Counties should work with the ACC to develop more streamlined methods for assisting patients with Medicaid and PCMP assignment. We get many referrals from counties who depend on us enrolling their patients into Medicaid. We have no access to funding to support this service.

h. What role should local public health agencies play in the next iteration of the ACC Program?
N/A

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past? N/A

45) How can RCCOs help to support clients and families in making and keeping appointments?
Reimbursement for reminder calls (i.e., robo calling) and assisting patients and providers with transportation costs.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP? Yes.

47) **Community Health Worker reimbursement**. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☒
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?
N/A

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you? All providers of BHOs must meet cultural competency standards. ARTS, as an entity within the University of Colorado, provides training on cultural competency.

b. What RCCO requirements would ensure cultural competency? N/A

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy? N/A

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes? N/A

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?
The idea of implementing preferred networks before the specialty providers have been identified and provided with an opportunity to educate the RCCOs and ACCs about their service provision is presumptuous and would further entrench misunderstanding and misinformation about specialty providers.

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend? N/A

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals. N/A

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☐	☐
Network provider education	☒	☐	☒	☐
Assistance with practice redesign	☐	☒	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☒	☐
Provide web-based resources and directories	☒	☐	☐	☒
Provide practice-specific data reports	☒	☐	☒	☐
Provide clinical care guidelines and best practices.	☒	☐	☒	☐
Provide clinical screening tools	☒	☐	☒	☐
Provide health and functioning questionnaires	☒	☐	☒	☐
Provide chronic care templates	☐	☒	☐	☐
Provide registries	☒	☐	☐	☒
Offer client reminders	☒	☐	☒	☐
Offer client self-management tools	☒	☐	☒	☐
Offer educational materials about specific conditions	☒	☐	☒	☐
Supply behavioral health surveys	☒	☐	☒	☐
Supply other self-screening tools	☒	☐	☒	☐
Administer behavioral health surveys	☒	☐	☒	☐
Administer other self-screening tools	☒	☐	☒	☐
Prepare client action plans	☐	☒	☐	☐
Provide training on providing culturally-competent care	☒	☐	☒	☐
Provide training to supporting staff	☒	☐	☒	☐
Provide training on motivational interviewing	☒	☐	☒	☐
Provide tools and software for phone call and appointment tracking	☒	☐	☒	☐
Provide tools and resources for tracking labs, referrals, etc.	☒	☐	☒	☐
Provide referral and transitions of care checklists	☒	☐	☒	☐
Provide visit agendas or templates	☒	☐	☒	☐
Provide standing pharmacy order templates	☒	☐	☒	☐
Provide comprehensive directory of community resources	☒	☐	☐	☒
Provide directory of other resources	☒	☐	☒	☐
Provide materials regarding Nurse Advice Line	☒	☐	☒	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☒	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.
The tools should be part of the HIT initiative and provide resources for other providers, such as SUD providers. The information could be extremely useful if it reflected population statistics and included metrics for measuring results.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?
Referral tracking, and standardization of referral documentation

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home? N/A

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population? N/A

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals? N/A

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation? N/A

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure? N/A

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding? N/A

63) What role – if any – should the RCCOs play in the distribution of payments to providers?
It would be very damaging for RCCOs to be involved in payment based on referrals.
What potential criteria could be used to distribute payments?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience: N/A

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured? Based off of population metrics, and regions where illness is more heavily concentrated so resources can be directed appropriately.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public? N/A

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-S0	☐
S1+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance? N/A

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-S0%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs? No, the key performance indicators should likely be very narrowly tailored to the needs of the region and the patients that they serve.

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement? N/A

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures. N/A

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

N/A

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☒
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☒	☐
Smartphone app	☐	☒
Other: These types of communication should have a rank order or some way to show preference. I think any way the Department is able to utilize new technology to create efficiency, such as text message or app, should be used.		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below: N/A

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☐	☐
Digital care management tool	☐	☐
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☑	☑
Health risk assessment software	☐	☐
Practice assessment tools	☐	☐
Practice management tools (scheduling, billing)	☑	☑
Client web portal for communicating care plan, services, benefit enrollment	☐	☐
Patient education/wellness tools	☐	☐
Provider/case manager directory	☐	☐
Shared decision-making tools	☐	☐
Telemedicine software	☑	☑
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type**. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☒	☐	☐
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☐	☒
Electronic Health Records (EHRs)	☐	☐	☐	☐	☐
Practice assessment tools	☒	☐	☐	☐	☐
Health risk assessment software	☐	☐	☒	☐	☐
Practice management tools (scheduling, billing)	☒	☐	☐	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☒
Patient education wellness tools	☐	☐	☒	☐	☐
Provider/case manager directory	☐	☐	☐	☐	☒
Shared decision-making tools	☐	☐	☐	☐	☒
Telemedicine	☐	☐	☒	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices? N/A

81) How can Health Information Technology support Behavioral Health Integration?
HIT could help BH Integration by identifying the specialty provider types, capacity, type of population served, and scope of services. HIT could expedite the transfer of DACOD and CCAR data.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.
*Diagnostic criteria that was met
*Diagnoses and expected treatment or prognosis
*Assessments, screens, survey results
*If diagnosed with a chronic disease then chronic disease management information

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.
N/A

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

The Department needs to aware of the significant cost for providers to make any changes to their EHR. Providers have to work with the vendor and within their current contract. User fees and contract costs continue to rise significantly every year. In order for substance use disorder providers to be successful with ACA expansion, they will need to have an EHR. This is a huge cost and something very new to a lot of SUD providers. Medicaid reimbursements need to keep up with the cost of doing business.

Colorado Department of
Health Care Policy and Financing

Serial #118

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
TH
IS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: John L. Bender, MD
Location: Fort Collins, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Bender Medical Group Inc, dba Miramont Family Medicine
Location: Fort Collins, CO
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty: Family Medicine
  ii. Area of practice: Fort Collins, Loveland, Wellington, Parker and Glendale
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official

How have you been involved in the ACC program and what interaction have you had with RCCOs:
Currently contracted with 4 of the RCCO's, regular interactions with various RCCO staff as part of the CPC Initiative. Largest book of business is with Rocky Mountain Health Plans, followed by Colorado Access and others.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:
Miramont Family Medicine is 38% Medicaid by revenues, serving over 5,000 Medicaid beneficiaries. We also have had contracts with Wyoming and Nebraska Medicaid due to our proximity to the border in the North.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)

☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☒ Since before the program was implemented.

☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

The best working part of the ACC is the additional financial incentives for the primary care providers. By offering not only the additional reimbursement to make us par to Medicare payments, but also with enhanced Care Coordination payments (paid as Per Member Per Month payments via an attribution method).

2) What is not working well in the ACC Program?

Paying the Medicaid "bump" up to 90 days in arrears creates cash flow problems, as it is essentially a "withhold" (our information is this will be corrected 1/1/2015). Shared savings in the CPC Initiative are being pooled, which means physician directed efforts that reduce costs could end up subsidizing hospital led efforts if they do not also create shared savings. Currently the PMPM fees are paid on the same Explanation of

benefits that regular claims are paid and as individual line items, thus creating considerable extra work for office billing staff to post these payments.

SDAC data is not available on a statewide basis, providers working more than one region must sign into each RCCO in order to retrieve fragmented provider data.

Attribution is an ongoing issue. For example, in Fort Collins many Medicaid enrollees choose another primary care provider, only to learn that provider cannot see them timely. Because Miramont offers after hours, Saturday and open access appointments, we may actually be the ones coordinating their care, but unable to claim the PMPM.

What is working best in the Behavioral Health Organization (BHO) system right now?

We were not able to create a functional model using the BHO system.

3) What is not working well in the BHO system?

We do not use the BHO's for our Medicaid population due to a lack of available appointments with wait times up to 6 weeks for a psychiatry consultation. Communication from BHO staff to our providers is difficult and rare. Billing the BHO for payment is incredibly cumbersome and paper based.

Instead, we have built our own in-house behavioral health services including a psychiatrist, three psychologists and a licensed clinical social worker. Historically, we have admitted many of our acute behavioral health patients to the neurology ward due to lack of local inpatient services. We conduct our own online psychiatric testing and provide multiple therapies, including EMDR.

4) What is working well with RCCO and BHO collaboration right now?

We have not seen any collaboration for our private sector ambulatory Medicaid population.

Behavioral Health Integration

5) What should be the next steps in behavioral health integration in Colorado?[1]

The BHO's can be dissolved and all behavioral health services brought into primary care offices using integrated care teams, medical records and payment model. Payment parity must exist for behavioral health (If Fee For Service is maintained) or an enhanced capitation payment (if ACO type payment is used).

The C-CARS forms are cumbersome, and need to be phased out.

6) Barriers to the integration of behavioral health and physical health services. Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	Barrier? No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	Yes, does not allow for integration between primary care and behavioral health in ambulatory care.
Community Behavioral Health Services Rule	☒	☐	C-CARS forms are cumbersome
Covered diagnoses list	☒	☐	All behavioral health diagnosis's should be covered
Different behavioral / physical health reimbursement	☒	☐	Does not allow for integration
Institutions for Mental Diseases exclusion	☒	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	
PCMP financing structure	☐	☒	As long as enhanced payment includes Behavioral Health and is paid monthly
Per-member per-month amount	☒	☐	Does not cover the cost of care coordination and behavioral health integration
Physical space constraints	☐	☒	We have room for behavioral health in our organization

[1] Many terms and definitions can be found in the Appendix at the end of this document.

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Privacy Laws (HIPAA, 42 CFR)	☐	☒	Integrated EHRs allow for privacy protection
Professional / cultural divisions	☐	☒	We have an integrated provider staff with many disciplines
RCCO or BHO contracts	☒	☐	HCPF must consider direct contracting with physician led ACO's as is occurring in Medicare.
Staff capacity	☐	☒	We allow staff to practice at the top of their scope.
State/Federal rules or reporting requirements	☐	☒	
Technical resources / data sharing	☒	☐	SDAC segregated by RCCO, no global enterprise information available
Training	☐	☒	
Others	Please type your response here.		

7) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

   A. Behavioral Health providers on staff and collocated with physical health providers
   B. Open access appointments for behavioral health and physical health
   C. Integrated electronic health record
   D. After hours on-call services for both behavioral health and physical health.

8) Please share any other general advice or suggestions you may have about behavioral health integration.

   A. Allow behavioral health providers to become part of "medical" provider networks and process payment for behavioral health and physical health with the same method.

   B. Report consolidated medical and behavioral health registries and claims data to identify patients with greater comorbidities and treatment needs.

   C. Allow for behavioral health telehealth visits statewide.

   D. Incentivize providers to match the level of behavioral health professional expertise to the clinical needs of the patient and to escalate behavioral health treatment intensity when improvement fails to occur.

   E. Propose behavioral health population metrics for desired behavioral health outcomes and incentivize progress towards these goals as pay for performance.

   F. Incentivize providers to apply evidence-based treatment algorithms and protocols as standard behavioral health interventions.

   G. Incentivize providers to use care coordinators trained in cross-disciplinary medical and behavioral support to create an integrated, comprehensive, whole-person personal care plan – to help patients with high health complexity overcome clinical and non-clinical barriers to improvement.

Care Coordination

9) What is the best definition of care coordination?

Care Coordination is the proactive implementation of the care plan between office visits that ensures patient and family engagement, as well and care plan completion across multiple providers and institution

10) How should RCCOs prioritize who receives care coordination first?

RCCO's must allocate care coordination services based on the twin inputs of cost drivers (SDAC reporting, claims data analysis) AND specific provider and beneficiary requests aware of emergent needs on a case-by-case basis.

a. How should RCCOs identify clients and families who need care coordination?

By asking the providers for regular feedback, and analysis of claims data and aggregate SDAC reporting.

b. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

Delegated care coordination can be reported monthly by the providers to HCPF. The reporting might include case number, resource referrals utilized, endpoints for care coordination.

11) What services should be coordinated and are there services that should not be a part of care coordination?

Services that <u>should</u> be coordinated include: Transitions of Care, specialty and diagnostic testing scheduling and transportation, community resource referrals, telehealth services, self-management and patient engagement education, updates to the care plan, and population health risk assessments.

Services that <u>should not</u> be coordinated include: Physical health and behavioral health as they must be collocated and integrated such that care coordination is not even necessary.

12) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

Information needed includes: Finances, legal issues, living arrangements, religious preferences, cultural preferences, and access to extended support systems (family, charity, etc.).

13) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

In our communities, our patients are receiving care coordination from the providers, hospitals, insurance companies, dental offices, cancer clinics, nursing home, hospice, and community care coordinators. Often, these coordinators are working separate agenda's with no communication with each other.

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

Ultimately, all in-state care coordination should take place outside of the RCCO, at the provider level. We need to serve the patients at point of care. Patients already have an established relationship with the providers and their care coordination teams.

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

It would be helpful for the ACC to provide resources for care coordinators to turn to for assistance, but not be directly involved in coordination of care with patients.

d. What are the gaps in care coordination across the continuum of care?

Transportation, lack of statewide health information exchange (no SNF, no Home Health on CORHIO for example), no home monitoring and telehealth tools widely adopted in the Medicaid program.

14) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☒	RCCO's – should be a resource to Care Coordinators in the field
Affordability (assistance with prescriptions or co-pays)	☒	☐	☒	Bundled payments to physician led ACOs would allow for in house solutions to copay and prescription assistance issues as no increased cost to HCPF.
Daycare / childcare	☒	☐	☒	RCCO should act as a resource to the provider offices
Economic stability & employment	☒	☐	☒	RCCO should act as a resource to the provider offices

Education	☒	☐	☒	RCCO should act as a resource to the provider offices
Environment	☒	☐	☒	RCCO should act as a resource to the provider offices
Food access / nutrition	☒	☐	☒	RCCO should act as a resource to the provider offices
Health literacy	☒	☐	☒	RCCO should act as a resource to the provider offices
Housing	☒	☐	☒	RCCO should act as a resource to the provider offices
Language or translation services	☒	☐	☒	RCCO could accommodate translation services remotely.
Literacy	☒	☐	☒	RCCO should act as a resource to the provider offices
Transportation	☒	☐	☒	RCCO could invest in vehicles and drivers
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

15) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	**Coordinate care?** Yes	No	**In what capacity should these individuals coordinate care in the ACC Program?**
Advanced Practice (Registered) Nurses	☒	☐	Setting Actionable Care Plans, Support Self-Management Goals, Eliminating Barriers to Care, Providing Educational Resources
Certified Addiction Councilors	☒	☐	Setting Actionable Care Plans, Support Self-Management Goals, Eliminating Barriers to Care, Providing Educational Resources
Certified Nurse Midwives	☒	☐	Setting Actionable Care Plans, Support Self-Management Goals, Eliminating Barriers to Care, Providing Educational Resources
Community Health Workers	☒	☐	Eliminate Barriers to Care, Link to Community Resources, Provide Educational Resources
Generalists (BA/BS/MA/MS)	☒	☐	Facilitate Transitions of Care, Support Self-Management Goals, Team Coaching, Provide Educational Resources

Health Coaches	☒	☐	Support/Track Progress of Self-Management Goals, Provide Educational Resources
Licensed Clinical Social Workers	☒	☐	Eliminate Barriers to Care, Link to Community Resources, Provide Educational Resources
Licensed Marriage and Family Therapist	☒	☐	Setting Actionable Care Plans, Support Self-Management Goals, Eliminating Barriers to Care, Providing Educational Resources
Licensed Mental Health Counselors	☒	☐	Setting Actionable Care Plans, Support Self-Management Goals, Eliminating Barriers to Care, Providing Educational Resources
Licensed Professional Counselor	☒	☐	Setting Actionable Care Plans, Support Self-Management Goals, Eliminating Barriers to Care, Providing Educational Resources
Masters of Public Health	☒	☐	Setting Actionable Care Plans, Support Self-Management Goals, Eliminating Barriers to Care, Providing Educational Resources
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	Setting Actionable Care Plans, Support Self-Management Goals, Eliminating Barriers to Care, Providing Educational Resources
Nurse Practitioners	☒	☐	Setting Actionable Care Plans, Support Self-Management Goals, Eliminating Barriers to Care, Providing Educational Resources
Patient Navigators	☒	☐	Setting Actionable Care Plans, Support Self-Management Goals, Eliminating Barriers to Care, Providing Educational Resources
Peer Advocates	☒	☐	Setting Actionable Care Plans, Support Self-Management Goals, Eliminating Barriers to Care, Providing Educational Resources
Promotoras	☒	☐	Setting Actionable Care Plans, Support Self-Management Goals, Eliminating Barriers to Care, Providing Educational Resources
Psychiatrists	☒	☐	Setting Actionable Care Plans, Support Self-Management Goals, Eliminating Barriers to Care, Providing Educational Resources
Psychologists	☒	☐	Setting Actionable Care Plans, Support Self-Management Goals, Eliminating Barriers to Care, Providing Educational Resources
Registered Nurses	☒	☐	Setting Actionable Care Plans, Support Self-Management Goals, Eliminating Barriers to Care, Providing Educational Resources

Social Workers	☒	☐	Setting Actionable Care Plans, Support Self-Management Goals, Eliminating Barriers to Care, Providing Educational Resources
Wraparound facilitators	☒	☐	Setting Actionable Care Plans, Support Self-Management Goals, Eliminating Barriers to Care, Providing Educational Resources
Other	Please type your response here.		

16) Care coordination requirements for specific populations. Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☐	Transition of Care, Breast Feeding, connecting with community resources
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☒	☐	Connecting with community resources
Children involved in the foster care system	☒	☐	Connecting with community resources and medical assistance
Children with a chronic illness	☒	☐	Transitions of Care, physician collaboration of care
Children with a serious emotional disturbance	☒	☐	Physician collaboration of care and behavioral health resources
Children with medical complexity	☒	☐	Transitions of Care, collaboration of care with physicians
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	Collaboration of care with physicians and behavioral health
Transition-age adolescents	☒	☐	Connection with community resources, Education
Parents and families	☐	☒	
Pregnant women	☒	☐	Connection with community resources, collaboration of care with physicians
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☒	☐	Connection with community resources
Adults with a chronic illness	☒	☐	Transitions of Care and collaboration of care with physicians
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	Collaboration of care with physicians and behavioral health, residential programs

Clients involved in the criminal justice system	☒	☐	Connection to community resources, probation officers, district attorneys
Clients with a disability	☒	☐	Connection to community resources
Clients in a nursing facility	☒	☐	Coordination with Skilled Nursing Facility, Families, Ombudsman.
Elderly clients	☒	☐	Connection to community resources
Frail elderly clients	☒	☐	Connection to community resources and collaboration of care with physicians
Clients in palliative care	☒	☐	Connection to community resources, Hospice and collaboration of care
Other populations, please comment:			

17) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

The RCCOs can facilitate conversations between the agencies themselves and the Patient Centered Medical Home. Alternatively, a physician directed ACO might assume this role.

18) How should care coordination be evaluated? How should its outcomes be measured?

At the aggregate practice level with reduced global costs of care, improved outcomes and improved patient satisfaction.

19) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

According the American Academy of Pediatrics the cost of coordination of care for patients is $22.00 - $33.00 per member per month. Miramont believes it can continue to deliver care coordination at a much lower cost of only $6-$7 per member per month to HCPF. Currently Miramont receives no PMPM from the RCCO's for care coordination, but uses offsets from other programs (CPC Initiative) to fund care coordination. These offsets are going away in 2015, so other sources of the payment need to be determined in the RFP.

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

Yes, utilize the same methodology that Medicare (Risk Adjustment Scores) uses to identify health risk. The higher the comorbidity of the patient, the higher the PMPM.

20) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population? Yes, and can be weighted by Risk Adjustment Factor scores

21) **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☒
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

Care Coordination can be assessed at the organization level by number of attributed lives, reductions in global health care costs over time, and patient satisfaction scores. Surrogate markers might also include reduction in ER utilizations, reductions in readmission rates, reductions in missed specialty and diagnostic testing appointments.

22) Please share any other general advice or suggestions you have about care coordination in the ACC.

There is a future role for community paramedicine here as well, directed at the provider led ACO level.

Program Structure

23) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

Payment methodologies and attribution are priority, along with statewide, aggregate claims data reporting such that organizations spanning more than one RCCO can see their composite data.

24) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

Marketplace size and penetrance, Medicaid attribution, provider network size, current contracts in place.

25) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

If the providers are not allowed to directly contract with HCPF as a Medicaid ACO, then then next best step is to allow the provider group to contract with only one RCCO and enroll all of its attributed lives to that RCCO.

26) Should the RCCO region maps change? Why or why not? If so, how?

The RCCO service areas need to compete across the state and not be granted exclusively to territories.

27) Should the BHO region maps change? Why or why not? If so, how?

The BHO's need to be folded into the RCCOs and not be separate in the first place.

28) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

The transition needs to start 6 months before a set "Go Live" date that corresponds to the fiscal year for the state.

29) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

HCPF needs to accommodate physician dispensing to Medicaid beneficiaries by removing the "twenty five mile" DORA restriction and recognize that in the future, all patients will need their clinical services and prescription services co-located for best compliance. Physician dispensing is safe, legal and potentially less costly than current models. HCPF has heard testimony as to the benefits and risks, and is aware of the proposed changes to the rule:

8.800.5.B. Dispensing Physicians ~~whose offices or sites of practice are located more than 25 miles from the nearest participating pharmacy~~ may be reimbursed for drugs that are dispensed from their offices and that shall be self-administered by the client

What are the limitations of the current benefit structure and what – if any – changes are needed?

Integrating the BHOs with the RCCOs is the most important immediate step for payment reform, administrative simplification and improved health care access and quality.

30) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

The RCCO service areas need to compete across the state and not be granted exclusively to certain territories. Competition will drive costs down and lead to standardization of services by the RCCO's/

31) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

N/A

32) What role should RCCOs play in attributing clients to their respective PCMPs?

The RCCO's can help match a monthly provider report against an attribution report and then report back to the provider discrepancies (patients attributed but not being seen, and patients being seen but no attributed).

33) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

Eventually certain public health services need to be integrated into the ACC as well, especially immunizations.

34) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

It would help providers and beneficiaries tremendously if newly eligible Medicaid are added as soon as possible to the ACC program. We do have new patients turned to collections only because of this delay, and it is difficult to re-instate patients once they are in collections.

35) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

Keep the website for enrollment integrated, this works well. Reduce churn by continuing to facilitate seamless coverage between payers.

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Large integrated care delivery models demonstrating higher quality care at a lower cost need reductions in oversight for scope and less restraint of trade in all areas of health care delivery. DORA was designed to protect the public from what were historically cottage-industry health care delivery models. Clinically

integrated models that externally report population health metrics and are collaborating in the RCCO need less oversight for scope issues.

Stakeholder Engagement

37) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

A commitment to see they are attributed to a PCMH or ACO within their network.

38) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

RCCO's must be willing to delegate care coordination to providers and assist those care coordinators in brokering relationships with community organizations, social service providers and others.

39) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

Community leaders must be educated about the value a coordinated care experience brings to their Medicaid population and community in general as a poverty and waste reduction strategy.

40) How should the Department structure stakeholder engagement for the ACC as a whole?

Shared savings to stakeholders will create a winning incentive that will lead to best practices that can be shared by the department in learning collaboratives for stakeholder groups.

Network Adequacy and Creating a Comprehensive System of Care

41) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

a. If no, what are the gaps?

We currently have gaps in specialty care providers, some dental care, and non-medical providers. Pharmaceutical dispensing needs to include physician dispensing to shore up the remaining compliance gaps.

Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

Maternity services are rationed at the hospital owned clinic level. Many of our obstetrics patients travel out of town for care.

42) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

The must be compelled to accept all Medicaid, and deny outpatient services.

b. What role should pharmacies play in the next iteration of the ACC Program?

Bundled payments to ACO's will help reduce pharmacy costs.

c. What role should specialists play in the next iteration of the ACC Program?

Bundled payments to ACOs will help reduce specialist costs and increase specialist participation

d. What role should home health play in the next iteration of the ACC Program?

Home health needs to be integrated into Health Information Exchange, CORHIO, and shared savings at the ACO level.

e. What role should hospice care play in the next iteration of the ACC Program?

Hospice needs to be integrated into Health Information Exchange, CORHIO, and shared savings at the ACO level.

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

43) How can RCCOs help to support clients and families in making and keeping appointments?

Support the care coordinators working at the PCMH provider level. We know who misses their appointments and why, and need resources to dispatch for transportation, interpretation, and chaperoning.

44) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

Not necessarily, we already provide this service as part of our PCMH

45) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☒
On staff (salary) at Primary Care Medical Provider Clinic	☒
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☒

46) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

Miramont Family Medicine has recently received a grant from the Delta Dental Foundation to integrate a dental hygienist into our primary care practice. Our hygienist is licensed to do consultations, x-rays, cleanings, root-scaling, and to oversee our Cavity Free by Three program. Our hygienist will be working with our dental community to ensure care of all our patients dental needs. Where we need assistance is ensuring that we have places to refer our patients if they have significant dental needs that are beyond the scope of our dental hygienist.

47) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

It means reducing health disparities and provider optimal care to patients regardless of their race, ethnic background, native languages spoken, and religious or cultural beliefs.

b. What RCCO requirements would ensure cultural competency?

The RCCO's can require provider not discriminate or disparage a patient's cultural or religious heritage.

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

Clinics will need to be respectful and be able to communicate with patient on their level of understanding. This can be achieved by either providing staff trained in the culture or in the language needed or by providing access to needed personnel or services.

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

Training program that aim at enhancing the cultural competence of healthcare providers by teaching and developing cross-cultural communication skills.

48) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

The preferred network must support "Fair Trade" primary care, meaning that if the preferred network reduces its own costs only by creating a new burden of transaction costs on the PCMH, then over time the PCMH will not be sustainable and global costs will rise.

A much better alternative is a provider directed ACO payment model wherein there are shared savings to ACOs that improve care and lower costs by incentives.

49) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

Incentivize PCMHs to stay open late and perform urgent care type services, like Xray, lab and I therapy. DO this with payments par to Medicare, timely payment of claims without quarterly withholds (as they are paid now), enhanced PMPM that includes care coordination fees of $6-$7 per month to the PCMH, and a pathway to a physician directed ACO payment standard that includes shared savings allocated by clinic or organization.

50) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Gaps are regional. We have no children's hospital in Larimer County, they all go to Children's ER in Aurora when sick, no direct admission unfortunately. We do have new access to Dental, pain management and behavioral health at Miramont but much of this we built internally.

Practice Support

51) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☒	☐	☒	☒
Network provider education	☒	☐	☐	☐
Assistance with practice redesign	☒	☐	☐	☐
Assistance with efficiency-enhancing activities	☒	☐	☐	☐
Provide web-based resources and directories	☒	☐	☒	☒
Provide practice-specific data reports	☒	☐	☒	☐
Provide clinical care guidelines and best practices.	☐	☐	☒	☒
Provide clinical screening tools	☐	☒	☐	☐
Provide health and functioning questionnaires	☐	☐	☒	☒
Provide chronic care templates	☐	☒	☐	☐
Provide registries	☐	☒	☐	☐
Offer client reminders	☐	☒	☐	☐
Offer client self-management tools	☐	☒	☐	☐
Offer educational materials about specific conditions	☐	☒	☐	☐
Supply behavioral health surveys	☐	☒	☐	☐
Supply other self-screening tools	☐	☒	☐	☐
Administer behavioral health surveys	☐	☒	☐	☐
Administer other self-screening tools	☐	☒	☐	☐
Prepare client action plans	☐	☒	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☒	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☒	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☒	☐	☐
Provide referral and transitions of care checklists	☐	☒	☐	☐
Provide visit agendas or templates	☐	☒	☐	☐
Provide standing pharmacy order templates	☐	☒	☐	☐
Provide comprehensive directory of community resources	☒	☐	☒	☒
Provide directory of other resources	☒	☐	☒	☒
Provide materials regarding Nurse Advice Line	☒	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☒	☒
Others				

52) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

Basically web based (Cloud) and if at the state level, to ensure that the RCCOs all have the same standards for best practices etc.

53) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

A coach will be needed order to help build robust, efficient and to become patient centered medical homes. A outside of practice coach, keeps the team centered, focused and moving forward by setting goals for the practice to meet NCQA standards.

54) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

Fee for Service is dead. Reimbursement must be quality based. Per Member Per Month payments based on the patient's health risk, NCQA Patient Medical Home Recognition Level, Shared Savings, and patient outcomes, is how providers should be reimbursed in the future.

A provider directed ACO payment model with payments par to Medicare, timely payment of claims without quarterly withholds (as they are paid now), enhanced PMPM that includes care coordination fees of $6-$7 per month to the PCMH, and a pathway to this physician directed ACO payment standard that includes shared savings allocated by clinic or organization.

55) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

Yes, and bi-directional interfaces need to be built. CIIS has promised this for years, still no deliverable.

56) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

57) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

Only partially. We need ongoing payments par to Medicare, timely payment of claims without quarterly withholds (as they are paid now), enhanced PMPM that includes care coordination fees of $6-$7 per month to the PCMH, and a pathway to a physician directed ACO payment standard that includes shared savings allocated by clinic or organization.

58) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

Absolutely, we are willing to accept capitation payments under a shared saving model. We would be willing to take primary care, specialty care and prescription medication downside and upside risk (we would add our Medicaid patients to our stop loss insurance).

59) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

CORHIO remains clunky for health information exchange, and CIVCH has payment but not quality data for reporting value. It will largely depend on the size of the physician organization. Solo providers will need to align with a RCCO, IPA or ACO. Larger groups, like ACO's and some IPAs are already doing this for Medicare Part C, and commercial payers.

60) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

We do not currently hold and LSLPN or HMO license with the DOI, but are certainly willing to obtain if required.

61) What role – if any – should the RCCOs play in the distribution of payments to providers?

If the payment methodology remains per member per month, then the state can administer the payment as they currently do. If the shared savings are outside of an ACO model, then the RCCO's will be heavily involved. Monthly meeting would be necessary with the providers to assess metrics and goals.

62) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

A provider directed ACO payment model, moving past payments made par to Medicare, timely payment of claims without quarterly withholds (as they are paid now), enhanced PMPM that includes care coordination fees of $6-$7 per month to the PCMH, and a pathway to a physician directed ACO payment standard that includes shared savings allocated by clinic or organization.

63) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

Quality metrics (CQMs) should mirror other initiatives like PQRS and the CPC Initiative. They should include chronic care metrics for diabetes and cardiovascular disease and prevention, patient satisfaction survey scores, and reduction in global care costs.

64) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☒	☒	Depends. It is expensive and patients do not always respond to the surveys. Perhaps as an annual measure?
SF-12 Health Survey	☐	☒	
Other types of client interviews / surveys	☒	☐	In clinic survey monkey type surveys, low cost and higher participation rates.
Patient Activation Measure	☒	☐	
Focus groups	☒	☐	
Other	Please type your response here.		

65) Knowing that, at this time, the Department only has claims data, how should population health be measured?

Allow the providers to externally report their population health in the meantime.

66) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

Choose a convener like Health Team Works that does this well already.

67) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☒
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

68) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☒
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

69) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Yes and yes

70) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Start with improvement, and move towards national standards.

71) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

Yes, it needs to be monthly in order for practices to understand whether their interventions are impacting care delivery.

72) Incentive payment frequency. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☒
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

73) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

I believe many of the fixed transaction cost of operating a RCCO will disappear in a direct payment to provider lead ACO model.

74) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Yes, we participate in CQM's' for PQRS, Bridges to Excellence, external reporting for the CPC Initiative, internal measurements with a digital tool called CINA, and we receive HEDIS bonus payments from some commercial payers.

Health Information Technology (HIT)

75) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☒
Text message	☐	☒
Web portal	☐	☒
Email	☐	☒
Telemedicine / Video chat	☐	☒
Face-to-face meeting	☐	☒
Smartphone app	☐	☒
Other: The more tools the more we can build (If the only tool is a hammer, we eventually start hammering screws.....).		

76) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☐
Digital care management tool	☒	☐
Care transitions alerts	☒	☐
Electronic Health Records (EHRs)	☒	☐
Health risk assessment software	☐	☒
Practice assessment tools	☒	☐
Practice management tools (scheduling, billing)	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☐
Patient education/wellness tools	☒	☐
Provider/case manager directory	☐	☒
Shared decision-making tools	☒	☐
Telemedicine software	☒	☐
Other: Smart phone apps for patient monitoring	☐	☒
Other:	☐	☐

77) **Importance of technology by type**. The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and S are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☒	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☐	☐	☒
Health risk assessment software	☐	☐	☐	☒	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☐	☒
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☐	☒
Patient education wellness tools	☐	☐	☐	☐	☒
Provider/case manager directory	☐	☐	☐	☒	☐
Shared decision-making tools	☐	☐	☐	☒	☐
Telemedicine	☐	☐	☐	☐	☒
Other: Smart phone apps with patient ambulatory monitoring	☐	☐	☐	☐	☒

78) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Cost to obtain and maintain hardware/software and low payment for telemedicine services.

79) How can Health Information Technology support Behavioral Health Integration?

Sharing of electronic health records, singular billing and revenue cycle management.

80) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

Must allow easy filtering of data and allow for trending data over time. Must be statewide, not segregate providers by RCCO or region when the provider works more than one contract.

81) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

Smart phone app to track patient choices and provider feedback, allow for dialogue.

82) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

Ideally would have access by all care managers, providers the RCCO and the PCMH.

83) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

Specialty, procedures, affiliated hospital or ASC, hours of operation, wait time.

84) How can the RCCOs support providers' access to actionable and timely clinical data?

Monthly push reports that rank "hot-spotters" by cost centers, copy to the physicians care coordinator.

85) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

Patient smart phone and iPad/Tablet apps that link to biosensors and allow for remote patient monitoring at home and ambulatory. Must integrate with CORHIO and EHR.

86) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

Ongoing training for SDAC.

87) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

CORHIO must be built, it is too fragmented and glitchy.

88) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

CLOUD based, smart phone accessible if to be relevant in 2020.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 119

Accepted by: KJDW

Notes: Formatting standardized

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Manthan Bhatt
Location: Denver, CO 80210

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Colorado Academy of Family Physicians
Location: Aurora, CO80014
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☒ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☐ Other (please describe): Click here to enter text.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☒ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:

The Colorado Academy of Family Physicians advocated for the creation of the RCCO's and the ACC program before it was implemented. We worked on the original RFI and our members have seen the great benefits of the ACC program and the RCCOs.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

The Colorado Academy of Family Physicians is the largest organization devoted to primary care in Colorado. We serve as the champion for Colorado's Family Physicians with over 2,200 members. The CAFP and our physicians sit on numerous Medicaid committees and we work to optimize the provider relationship with the department. The CAFP supports the ACC program through communications and marketing efforts.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) **What is working best in the Accountable Care Collaborative (ACC) right now?**

The ACC has been successful in its efforts to create a strong provider network. It has also been successful in recruiting new physicians to meet the increasing demand that the Affordable Care Act has placed on the Medicaid program. The Regional Care Collaboratives (RCCOs) have helped enable care coordination for both providers and Medicaid beneficiaries. The program's is both accountable and transparent which allows the public to accurately measure the savings it has secured. The program has been successful in not only seeking provider feedback but implementing their suggested changes.

2) **What is not working well in the ACC Program?**

A major problem providers continue to face in the ACC program is that a practice's population falls under multiple RCCOs and the provider is forced to bring different care to different clients. Attributing providers to a single RCCO could help expand the ability for a provider to maximize RCCO services.

A provider contract that fully implements payment reform with global capitation and global risk has been talked about but not implemented. Primary care physicians are in a unique position to slow the cost of health care while, at the same time, expanding care. A global capitation and global risk contract could help attract high-functioning PCMHs and medical homes into the program because those contracts incentivize and reward work already being done. Unless a fair global risk contract can be created, PCMPs should receive their income from 3 sources, adequate FFS, a higher PMPM and bonuses for hitting quality measures.

The current key performance indicators (KPI's) are insufficient in assessing the quality of most practices as they are financially driven, not medically driven. High functioning primary care offices should be able to bring data about their diabetic populations (percent of beneficiaries with diabetes HbA1c in poor control), their hypertension populations (percent of beneficiaries with hypertension whose blood pressure is in poor control), percentage of population receiving depression screening, percent of elderly population receiving a screening for fall risk, tobacco use for population, high LDL population, etc. These KPIs, and the payments connected to them, should be voluntary but encouraged via shared savings.

Our providers have found that the rate increase process the Department of Health Care Policy and Financing plans for are retroactive which discourages long term planning. In order to secure more providers, the department could create long term plans for the determination of rate increases.

We need to hold Medicaid patient's accountable. Currently providers are not allowed to charge for "No Show Appointments". We understand that these people qualify for Medicaid because they meet the Federal Government Poverty Guidelines, but we need some accountability from the patients. An important way to ensure patient accountability is to incentivize them through financial accountability.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

Large FQs and Medicaid offices are co-locating BHO staff which encourages warm handoffs between primary care physicians and the behavioral health team.

4) What is not working well in the BHO system?

The BHOs need to contract with the RCCOs and receive o combined PMPM poyment in order to simplify HCPF occounting ond make possible ony risk contracting in the future. Encouraging the co-locotion of BHO stoff ot large Medicold offices or FQ's would be ideol. For smoller offices, partnering with BHO orgonizations in their community to refer oll clientele could help in encouraging referrals to BHOs.

The current limitotions in Medicold's behaviorol heolth program could be mitigoted by ollowing privote practice behoviorol heolth professionols to contract directly with Medicoid, outside of the BHO. This could ollow PCMPs to codify current practices. For instance, we've heord clinics offering counseling for pay which many of their potients will do ot leost short term due to the issues with Medicaid counselling.

On the nationol level, HIPPA must be chonged to ollow the needed communicotion between BHO ond medicol offices. HCPF ond the ACC progrom should look into the process of receiving o woiver to enhance the collaboration between PCMPs ond BHOs.

Currently for PCMPs with Medicaid cliental have to go through o lengthy ond burdensome process to get any counselling help which hos coused many of our potients to not seek counseling, give up, or refuse to ever go bock because the process was so onerous. For many of these potients, getting a hondle on their behovioral health would dromaticolly affect their physicol heolth outcomes.

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

Behavioral Health Integration

7) **What should be the next steps in behavioral health integration in Colorado?**[1]

The HCPF department should move away from providing crisis management or short term counselling, like what is currently being offered at many FQHCs, and move to having an-sight, long term behavioral health counseling with rotating psychiatrists. Currently, our providers will offer counseling outside of Medicaid at a heavily discounted price due to issues with Medicaid's burdensome process to get counseling. Behavioral health, for many, is directly connected to physical health. For many of these patients getting a handle on their anxiety, PTSD, depression, etc would drastically alter their health outcomes.

Integrating the BHO regions with the current RCCO regions will help Medicaid beneficiaries navigate the system while also integrating the work RCCOs do with what BHOs. In order to integrate behavioral health with physical health, the department should consider contracting with the RCCOs to do both mental and physical health. In essence, one contract to ensure integration.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services.** Using the table below, please explain which issues are barriers, and how they can be addressed:

Factor:	Barrier? Yes	No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	Allow BHOs to contract with RCCOs to receive combined PMPM payment
Community Behavioral Health Services Rule	☐	☐	
Covered diagnoses list	☐	☐	
Different behavioral / physical health reimbursement	☐	☐	
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☒	☐	
PCMP financing structure	☒	☐	Global risk contracts could encourage the management of chronic and behavioral health diseases.
Per-member per-month amount	☒	☐	Our providers still see Medicaid patients at a loss, integrating behavioral health will require higher PMPMs.
Physical space constraints	☒	☐	Many small practices will never fully integrate with behavioral health because of space constraints. Having strong referral networks that follow up with patients could help mitigate the lack of in-office behavioral health support.
Privacy Laws (HIPAA, 42 CFR)	☒	☐	HIPPA must be changed to allow the needed communication between BHO and medical offices
Professional / cultural divisions	☒	☐	
RCCO or BHO contracts	☒	☐	In order to integrate behavioral health with physical health, the department should consider contracting with the RCCOs to do both mental and physical health. In essence, one contract to ensure integration.

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☐	☐	
Technical resources / data sharing	☐	☐	
Training	☐	☐	
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

Care coordination is the management and coordination of complex medical cases to ensure quality and efficient use of health care resources. Care coordination is greatly enhanced in the Patient Centered medical Home because it anticipates that family physicians and their team will provide care coordination services. Family physicians already utilize their team for coordination of services for their patients and assuring that appropriate testing and medication compliance occurs in a patient's treatment plan. Family Physicians should appropriately be paid for these services.

b. How should RCCOs prioritize who receives care coordination first?

Complex patients that are either pregnant or are children should receive care coordination services first. Top priority should also be given to those with mental illness, diabetes, a chronic illness and those with degenerative diseases.

c. How should RCCOs identify clients and families who need care coordination?

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

12) What services should be coordinated and are there services that should not be a part of care coordination?

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

b. What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

c. How can the ACC avoid duplicating or disrupting current care coordination relationships?

d. What are the gaps in care coordination across the continuum of care?

15) **RCCOs' roles in addressing clients' and their families' non-medical needs.** Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☐	☐	☐	
Affordability (assistance with prescriptions or co-pays)	☐	☐	☐	
Daycare / childcare	☐	☐	☐	
Economic stability & employment	☐	☐	☐	
Education	☐	☐	☐	
Environment	☐	☐	☐	
Food access / nutrition	☐	☐	☐	
Health literacy	☐	☐	☐	
Housing	☐	☐	☐	
Language or translation services	☐	☐	☐	
Literacy	☐	☐	☐	
Transportation	☐	☐	☐	

Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	Coordinate care? No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	
Certified Addiction Councilors	☒	☐	
Certified Nurse Midwives	☐	☐	
Community Health Workers	☒	☐	
Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☐	☐	
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☒	☐	
Licensed Mental Health Counselors	☒	☐	
Licensed Professional Counselor	☒	☐	
Masters of Public Health	☐	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	
Nurse Practitioners	☒	☐	
Patient Navigators	☒	☐	
Peer Advocates	☐	☐	
Promotoras	☒	☐	
Psychiatrists	☒	☐	
Psychologists	☒	☐	
Registered Nurses	☒	☐	
Social Workers	☒	☐	

Wraparound facilitators	☐	☐	
Other	Please type your response here.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☐	
Children	☐	☒	
Children who are healthy, but in socially-complex environments	☒	☐	
Children involved in the foster care system	☒	☐	
Children with a chronic illness	☒	☐	
Children with a serious emotional disturbance	☒	☐	
Children with medical complexity	☒	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	
Transition-age adolescents	☐	☒	
Parents and families	☐	☒	
Pregnant women	☒	☐	
Adults	☐	☒	
Adults who are healthy, but in socially-complex situations	☒	☐	Care coordination is needed for domestic violence victims. They are in a unique position that requires support.
Adults with a chronic illness	☒	☐	
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	
Clients involved in the criminal justice system	☒	☐	
Clients with a disability	☒	☐	
Clients in a nursing facility	☒	☐	
Elderly clients	☒	☐	
Frail elderly clients	☒	☐	
Clients in palliative care	☒	☐	
Other populations, please comment:			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

19) How should care coordination be evaluated? How should its outcomes be measured?

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

This problem could be easily fixed if PCMP's would be allowed to choose the RCCO they wish to belong to, not based on the county of residency of the member.

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

Don't change the maps as such but allow PCMP's to pick the RCCO that best fits their needs for their members.

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

No, we see gaps in specialty care, dental care, behavioral health and non-medical providers. Payment to specialists must be increased in order to assure adequate specialty networks for this population. Pharmacies in physician offices should be compensated in order to lessen the logistical burdens of obtaining prescriptions.

a. If no, what are the gaps?

There are not enough specialist within the ACC program. Adequate payment to specialists could help our PCMPs in referring complex patients out.

b. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

a. What role should hospitals play in the next iteration of the ACC Program?

b. What role should pharmacies play in the next iteration of the ACC Program?

c. What role should specialists play in the next iteration of the ACC Program?

d. What role should home health play in the next iteration of the ACC Program?

e. What role should hospice care play in the next iteration of the ACC Program?

f. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

g. What role should counties play in the next iteration of the ACC Program?

h. What role should local public health agencies play in the next iteration of the ACC Program?

i. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47) **Community Health Worker reimbursement.** Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

a. What does cultural competence mean to you?

b. What RCCO requirements would ensure cultural competency?

c. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

d. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☒	☐	☒	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☐	☐	☐	☐
Provide health and functioning questionnaires	☐	☐	☐	☐
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☒	☐	☒	☐
Offer client reminders	☒	☐	☐	☐
Offer client self-management tools	☒	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☐	☐	☐	☐
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☐	☐	☐	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☐	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☐	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☒	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☒	☐
Others				

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

Claims data can be a powerful tool to anticipate needs of a community. RCCOs should make use of current data and help PCMPs identify the needs of their population.

A registry of all Medicaid patients assigned to a PCMP so they know their populations.

For many small practices, seeing a Medicaid patient is unique. The RCCOs need to provide a directory of their resources and the overall resources available in the ACC program.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

Yes, RCCOs are in a unique and financial position to support practices in practice transformation.

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

Disease registries are not necessary for chronic disease management, and are not incorporated in many EMR platforms. Using outside registries would require double data entry. Medical offices have quickly adopted EMRs but this is not a Medicaid requirement, yet.

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

We know of many large and mid-size primary care practices that would be interested in participating in capitation payments under a shared savings model.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Practices are at various stages of development. Most of our physicians, a little over 2/3rds according to our last census report, have an EHR. This is the first step to allow a provider to receive global payments. EHRs also require a registry function to receive these payments. Leadership and the commitment to quality based care and the ability to train support staff around that commitment is a barrier.

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

If the department is going to continue paying on a per member per month basis, then the state can administer the payments as they currently do. Under a global risk contract, the RCCOs will most likely be required to measure shared savings.

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

Quality metrics should include, chronic care metrics for diabetes and cardiovascular disease and prevention, patient satisfaction survey scores, and reduction in global care costs.

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☒	Too expensive and patients do not respond to the surveys.
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

By physician quality data and reduction in global costs.

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

State registry like SDAC, but allow for provider uploads of quality data.

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☒
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

Yes

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

Yes

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

Yes

74) **Incentive payment frequency**. Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☒
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Many practices and community providers get bonus HEDIS payments from commercial payers.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

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REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

ACC Request for Information

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Colorado Department of Human Services
Location: Denver, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: **Office of Behavioral Health**
Location: Denver, CO
☒ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☐ Medical provider / PCMP / other provider
  i. Type or specialty: Click here to enter text.
  ii. Area of practice: Click here to enter text.
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): state government agency

Are you currently involved in the ACC program?

☐ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☐ 3-4 years
☐ Since before the program was implemented.

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Click here to enter text.

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

Click here to enter text.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☐ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☒ N/A

Please feel welcome to describe why or why not using the space below.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

The ACC program has been able to effectively use data to drive outcomes. The creative use of financial incentives appears to be successful. The use of a health home model is a useful construct.

2) What is not working well in the ACC Program?

To date it appears that care coordination has been focused on acute episodes and is not comprehensive enough for clients with chronic conditions and multiple issues. In addition, Child Welfare has not understood the value of enrolling children in the ACC program.

3) What is working best in the Behavioral Health Organization (BHO) system right now?

There have been improvements in understanding payment responsibilities between the BHOs and the child welfare system.

4) What is not working well in the BHO system?

Many people who require intensive care are not receiving it. Persons with co-occurring disorders i.e. developmental disabilities, TBI and autism have a difficult time accessing care. In rural areas we hear many complaints about people being able to access care. There are not enough appointment times to allow clients especially those with severe needs to obtain appointments at the appropriate frequency. There are not clear outcomes for success and limited monitoring of outcomes and quality care. The BHOs have very limited oversight. Many SUD providers have not been able to access BHO reimbursement.

There is also a problem working across BHO regions. In some cases there may be a need to change BHOs in the middle of care and eligibility and continuity of care may be interrupted.

In addition, some BHOs are making level of care decisions for children without any face to face assessments.

Medical necessity is not uniformly applied across the system and is not well understood. This sometimes results in the premature interruption of evidence based programs.

5) What is working well with RCCO and BHO collaboration right now?

6) What is not working well with RCCO and BHO collaboration right now?

There needs to be more coordination across physical and behavioral health. There is a lack of data sharing and disorders that cross over domains are inadequately addressed such as TBI, autism etc.

Continuity of care is often weak such as when a person may leave the institutes. In addition, there needs to be a seamless system when clients must cross over RCCO or BHO regions.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

Geographic regions between BHOS and RCCOS should be aligned and one administrative structure should be developed. However, it is important that behavioral health knowledge be kept in the system. The work of the SIM planning grant should be utilized in moving this forward. It is recommended that the definitions of integrated healthcare developed by Center for Integrated Health Solutions be utilized and that the system be encouraged to stretch beyond collaboration to integration. (A Standard Framework for Levels of Integrated Healthcare, SAMHSA-HRSA April 2013) Steps that would be helpful in moving this work forward are as follows:

1) Align geographical areas of BHOs and RCCOs

2) Develop outcomes, quality of care standards, evidence based practices and shared performance measures that address physical health, mental health and substance abuse.

3) Address coding issues so that behavioral health workforce such as peer specialists can bill in physical health settings

4) Identify workforce needs and identify workforce shortages. Address workforce shortages by providing incentives, reasonable reimbursement rates and ensuring that the various disciplines work to the top of their credential which means for example that doctors may not be appropriate to serve as case managers.

S) Identify a common definition of medical necessity that is uniformly applied across the state. This would include criteria and standard tools and processes to determine level of care and ways to appeal when decisions are questioned.

[1] Many terms and definitions can be found in the Appendix at the end of this document.

8) **Barriers to the integration of behavioral health and physical health services. Using the table below, please explain which issues are barriers, and how they can be addressed:**

Factor:	Barrier? Yes	Barrier? No	If yes, please provide details of the barrier and how to address it:
Community Mental Health Center financing structure[2]	☒	☐	Should work with OBH to most effectively target block grant dollars to address gaps in funding. OBH and HCPF can align incentives.
Community Behavioral Health Services Rule	☐	☒	Although this may be a perceived barrier there are no rules that are a barrier to integrated care.
Covered diagnoses list	☒	☐	If care is integrated this should be less of a barrier but now many are denied behavioral health care because of this issue. Even when care is integrated effective ways of addressing conditions like autism and developmental disability have to be developed.
Different behavioral / physical health reimbursement	☒	☐	The difference between fee for service and capitation provides different incentives. The integrated financing structure should be aligned with incentives that support positive outcomes. There are also differences in credentialing in both systems and limitations as far as what health and behavioral health codes can be accessed in what setting
Institutions for Mental Diseases exclusion	☐	☐	
OBH rules, reporting, or financing (regulatory differences between agencies)	☐	☐	In many cases this is a perceived barrier. Reporting may be an issue with current data processes. However, OBH is in the middle of a system redesign which will address some of these processes.
PCMP financing structure	☐	☐	
Per-member per-month amount	☒	☐	Needs to be a differential amount based on acuity
Physical space constraints	☐	☐	
Privacy Laws (HIPAA, 42 CFR)	☒	☐	Need to make sure we have clear information on what is perceived and what is a real barrier. Can use Qualified Service Organization Agreement. Also support the federal work happening to restructure HIPPA and 42 CRF.

[2] More information about these rules, payment types, and entities can be found in the Appendix at the end of the document.

Professional / cultural divisions	☒	☐	
RCCO or BHO contracts	☒	☐	Should be one contract.
Staff capacity	☐	☐	
State/Federal rules or reporting requirements	☒	☐	Mental Health Block Grant requires the collection of certain data
Technical resources / data sharing	☒	☐	Would be helpful to use electronic health record as platform but need for all providers to have easy access both to put in information and to have back any relevant information. Costs for technical solutions are also very expensive. Having a statewide strategy for vendor management could be helpful in reducing costs.
Training	☐	☐	
Others	Please type your response here.		

9) What characteristics are necessary for the State to recognize a clinic as providing integrated, whole-person/whole-family physical and behavioral health care?

Meet the criteria in *A Stondord Fromework for Levels of Integroted Heolthcore* cited in question 7 and...

1) Provide regular behavioral health screening questions in an overall health questionnaire and with secondary or more in depth screens for positive responses or high risk populations;
    a. Should include at a minimum depression, trauma, SBIRT, developmental screening
2) Easy access to behavioral health staff
3) A trauma informed setting
4) Co- training for staff at all levels
5) Services provided in a team based approach
6) Care coordination that matches the level of acuity of the person's need and goes beyond health concerns to address related issues such as economic security and housing.
7) Address the use and monitoring of psychotropic medications
8) Clear shared outcomes and performance and quality measures
9) Access to wellness education, activities and resources

Suggest thot stotuory outhority be sought for oversight of these clinics including o role for OBH in monitoring quolity behoviorol heolth services

10) Please share any other general advice or suggestions you may have about behavioral health integration.

Address the need of smaller providers for example substance abuse providers in being able to be certified in electronic healthcare records

Care Coordination

11) Care coordination is an important part of the ACC Program.

a. What is the best definition of care coordination?

An individualized process often team based that identifies the individual's or family's needs and works to access and mobilize resources needed to address those needs. The most comprehensive care coordination process works across life domains and seeks to build on the individual's strengths and seeks to develop skills for the individual/family to subsequently meet their own needs.

b. How should RCCOs prioritize who receives care coordination first?

High Utilizers and individuals transitioning from hospital or residential level of care would be top priorities as well as those who have a chronic conditions including behavioral health.

c. How should RCCOs identify clients and families who need care coordination?

Certain high risk populations could be identified using data. In addition the health providers in the network could screen their patients to identify those in need of care coordination using agreed upon criteria. Those without adequate support, and or those with complex social situations would be prime candidates for care coordination. Clients should also have the opportunity to self-identify. They should be given information about the benefit and have a mechanism to request it.

d. How should RCCOs track care coordination when the care coordination takes place at a delegated Medical provider?

All care coordination activities should be entered into a common database that is monitored by the RCCO. Standards/guidelines should be developed for various levels of care coordination.

12) What services should be coordinated and are there services that should not be a part of care coordination?

All services necessary to meet the needs identified by the client and that are part of the care plan should be a part of care coordination.

13) What pieces of information are most important to have about someone in order to know what care coordination he or she needs?

What systems is the person involved with, housing situation, what are the current pressing needs, how successful has the person been in the past addressing similar issues. Level of functioning-severity of symptoms is likely the most important criteria.

14) Many clients and their families have access to a number of different care coordinators. These coordinators often work in different systems.

a. What care coordination is going on today?

Child welfare, developmental disabilities, Part C, some mental health centers, criminal justice, and transition specialists funded through OBH for clients leaving the institutes

What care coordination takes place outside of the RCCO or ACC, and what makes that coordination different?

All of the above. It is usually related to a particular system need and often does not address the individual or family comprehensively.

b. How can the ACC avoid duplicating or disrupting current care coordination relationships?

If the current relationships are working the ACC can simply add the access to health services if needed and if the coordination is not effective in helping the individual meet his or her needs the ACC can serve as a super care coordinator and convene the other coordinators to ensure a coordinated plan and clear accountability.

c. What are the gaps in care coordination across the continuum of care?

Individuals/families with complex needs and those with co-occurring disorders and transition age youth. Services are also not organized for families.

15) RCCOs' roles in addressing clients' and their families' non-medical needs. Please complete the table below, keeping in mind adults, children, and families:

Non-medical need:	Should the RCCO have a role? Yes	No	Should the RCCOs coordinate with community supports and services? Yes	Should the RCCOS have an additional role beyond coordinating with these supports? If so, what should that role be?
Abuse, neglect, and trauma	☒	☐	☐	Assure access to trauma assessments and trauma treatments-assure providers in network are trauma informed
Affordability (assistance with prescriptions or co-pays)	☒	☐	☐	RCCOs should actively address these issues as they may be direct barriers to care.
Daycare / childcare	☒	☐	☒	This may be a barrier to client's accessing care so the RCCO should make connections in the community that can address this as well as perhaps provide some childcare on site.
Economic stability & employment	☒	☐	☒	
Education	☒	☐	☒	
Environment	☒	☐	☒	
Food access / nutrition	☒	☐	☐	
Health literacy	☒	☐	☐	
Housing	☒	☐	☐	Although this will take coordination with existing resources this is an important barrier to health so should be actively addressed by RCCO care coordination

Language or translation services	☒	☐	☐	
Literacy	☐	☐	☒	
Transportation	☒	☐	☐	Mobile Services, Tele-medicine and having system interfaces that are compatible with mobile devices is crucial to meet needs of rural clients.
Other	Please type your response here. Feel free to list as many non-medical factors as you want, and please explain how the RCCO should be involved.			

16) **Requirements about who should be doing care coordination.** Care coordination is often a team effort with several people with different skills working together to serve Clients and families. Please use the table below to describe who should be a part of coordinating care and what roles those different people should play:

Type:	Coordinate care? Yes	No	In what capacity should these individuals coordinate care in the ACC Program?
Advanced Practice (Registered) Nurses	☒	☐	
Certified Addiction Councilors	☒	☐	
Certified Nurse Midwives	☒	☐	
Community Health Workers	☒	☐	
Generalists (BA/BS/MA/MS)	☒	☐	
Health Coaches	☒	☐	
Licensed Clinical Social Workers	☒	☐	
Licensed Marriage and Family Therapist	☒	☐	
Licensed Mental Health Counselors	☒	☐	
Licensed Professional Counselor	☒	☐	
Masters of Public Health	☒	☐	
Medical Doctors / Doctors of Osteopathic Medicine	☒	☐	
Nurse Practitioners	☒	☐	

Patient Navigators	☒	☐	
Peer Advocates	☒	☐	
Promotoras	☒	☐	
Psychiatrists	☒	☐	
Psychologists	☒	☐	
Registered Nurses	☒	☐	
Social Workers	☒	☐	
Wraparound facilitators	☒	☐	For complex children with issues across systems
Other	Any of the people listed could serve as a care coordinator or as a member of the team. In order to address workforce shortages it is important to utilize people to the top of their credential allowing some tasks to be provided by others in a team approach.		

17) **Care coordination requirements for specific populations.** Please use the table below to describe if any of the following populations require unique care coordination requirements, or if general requirements are sufficient:

Population	Specific	General	If specific, please describe
Newborns and infants	☒	☐	
Children	☒	☐	
Children who are healthy, but in socially-complex environments	☒	☐	
Children involved in the foster care system	☒	☐	
Children with a chronic illness	☒	☐	
Children with a serious emotional disturbance	☒	☐	
Children with medical complexity	☒	☐	
Children or youth with a behavioral health diagnosis or substance use disorder	☒	☐	
Transition-age adolescents	☒	☐	
Parents and families	☒	☐	
Pregnant women	☒	☐	
Adults	☐	☐	
Adults who are healthy, but in socially-complex situations	☒	☐	
Adults with a chronic illness	☒	☐	
Adults with a behavioral health diagnosis or substance use disorder	☒	☐	

Clients involved in the criminal justice system	☒	☐	
Clients with a disability	☒	☐	
Clients in a nursing facility	☒	☐	
Elderly clients	☒	☐	
Frail elderly clients	☒	☐	Provided by OBRA/PASRR and PACE program
Clients in palliative care	☒	☐	
Other populations, please comment: transgender populations. All of the listed populations require specialized knowledge of developmental needs. In addition for those that cross systems it is necessary to have a thorough understanding of the various systems involved and the resources available.			

18) How do you envision the RCCOs working with child-serving agencies in the state to deliver care for medically or socially complex children or for children involved in the foster care system?

The RCCO might have a special unit or a delegated specialty care coordination agency or in fact there may be specialty RCCOs for the populations described above. The RCCO through one of the arrangements described above may serve as a super coordinator ensuring that plans are coordinated and that progress is being made.

19) How should care coordination be evaluated? How should its outcomes be measured?

The goals in the plan should be met. The person or family is able to address their own needs.

20) Today, RCCOs receive $8-$9 per member per month (PMPM) to cover care coordination and other expenses, like developing and supporting a network of providers.

a. What is the PMPM cost for providing care coordination services?

b. Is it advisable to have the PMPM vary by specific population? If so, what would be the recommended PMPM cost by population?

Yes for populations needing intensive services the care coordination ration should be 1 to 10. Populations or individuals with high acuity, complex situations, and multi-system involved and high utilizers should be targeted for intensive care coordination.

21) Should there be care coordinator to client ratio requirements in the next RFP? How should this vary by client acuity or population?

Yes. For high acuity the ratio should be fewer than 25.

a. **Care coordinator to client ratios.** If you answered "yes" to the previous question: with roughly 45% adults, 55% children, and with 6% of covered clients having disabilities, please estimate how many clients one care coordinator can serve. Please use the table below for your response:

Clients	
Fewer than 25	☐
26-50	☐
51-100	☐
101-200	☐
201-500	☐
501-1,000	☐
1,001-1,500	☐
1,501-2,000	☐
2,001-3,000	☐
3,001-4,000	☐
4,001-5,000	☐
More than 5,000	☐

22) How should care coordination outcomes be evaluated by the Department? Which metrics are most important?

Quality of care as experienced by the consumer, consumer outcomes achieved, person stable in physical health and or behavioral health regime (medication adherence, monitoring of symptoms and action plans etc.,) and social needs such as housing or employment are met.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

As stated in other questions the level of care coordination should be directly related to the acuity of the client's needs defined not only by the health condition but the level of complexity due to social factors and other system involvement.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

25) What should be required of a bidder to ensure that, as a RCCO, it could form community relationships and understand community strengths and needs?

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

27) Should the RCCO region maps change? Why or why not? If so, how?

28) Should the BHO region maps change? Why or why not? If so, how?

29) Based on the current scope of work for RCCOs, how many months of transition would new vendors require? What needs to happen during the transition period? What are the expenses involved in this transition?

30) What legislation, policy, rules, or changes in procedure are needed to make the ACC more effective?

31) What are the limitations of the current benefit structure and what – if any – changes are needed?

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

33) If you or your practice provide services to clients referred through a BHO, but you are not a Medicaid provider, would you be willing to become a Medicaid provider? If so, what has prevented you from becoming a provider in the past? If not, why not?

34) What role should RCCOs play in attributing clients to their respective PCMPs?

35) What types of collaboration should exist between the ACC Program and the Colorado Department of Public Health and Environment?

36) What types of collaboration should exist between the ACC Program and the Colorado Department of Human Services?

The Office of Behavioral Health should be involved in selecting behavioral health tools, designing integrated practice, selecting outcomes and sharing data and monitoring practice. The ACC Program should coordinate with the new crisis system and work with OBH to develop community capacity for start-up of new programs and training. The Office of Early Childhood should play a role in determining screenings and best practices with young children. Child Welfare should be involved to create more integration between systems.

37) What types of collaboration should exist between the ACC Program and the insurance marketplace / Connect for Health Colorado?

38) What types of collaboration should exist between the ACC Program and the Colorado Department of Regulatory Agencies or the Division of Insurance?

Stakeholder Engagement

39) What should be required of the RCCOs in terms of stakeholder engagement with clients, clients' families, and client advocates?

40) What specific requirements should RCCOs have for stakeholder engagement with providers, community organizations, social service providers, and others in their region?

41) Many of the successes of the ACC Program can be attributed to the involvement of local communities. How can enhanced community engagement be created in the ACC?

42) How should the Department structure stakeholder engagement for the ACC as a whole?

Network Adequacy and Creating a Comprehensive System of Care

43) Does the current network of PCMPs, specialists, behavioral health providers, hospitals, pharmacies, dental, home health, and non-medical providers adequately serve the ACC population?

No. Persons with complex behavioral health issues are not able to see psychiatrists frequently enough. Not enough 24 hour care. Not enough SUD credentialed providers, overall shortage of behavioral health staff.

There is also a lack of providers with deep trauma knowledge and ability to work with child welfare clients. There is a lack of providers trained in co-occurring issues and a lack of providers that can work with transition age youth. Through OBH data we have learned that engagement is weakest with transition age youth.

a. Please address gaps for the population as a whole, and for specific subpopulations such as children/families and individuals with disabilities.

b. What is the role of regional centers. Huge gap besides those mentioned elsewhere in this document are DD/MI or any co-occurring disorders

See above.

44) ACC Clients and the RCCOs interact with many parts of the Medicaid program, as well as with service entities and other types of providers or facilities.

b. What role should hospitals play in the next iteration of the ACC Program?

c. What role should pharmacies play in the next iteration of the ACC Program?

d. What role should specialists play in the next iteration of the ACC Program?

e. What role should home health play in the next iteration of the ACC Program?

f. What role should hospice care play in the next iteration of the ACC Program?

g. What role should Single Entry Points (SEPs) and Community Centered Boards (CCBs) play in the next iteration of the ACC Program?

h. What role should counties play in the next iteration of the ACC Program?

i. What role should local public health agencies play in the next iteration of the ACC Program?

j. What role should community organizations and non-profits play in the next iteration of the ACC Program? Are there potential partnerships with these organizations which have been overlooked in the past?

45) How can RCCOs help to support clients and families in making and keeping appointments?

Reminders such as phone calls or text messages or letters in the mail as a routine part of business would be helpful. Assuring appointment times after school and work. Support the use of techniques that have been demonstrated to be effective such as an incentive program developed by the state of Iowa. Increase the use of mobile services and telehealth.

46) Community Health Workers are lay members of a community who provide coordination or help people to navigate the health care system in that community. Should the Department require Community Health Workers or Patient Navigators as part of the next RFP?

47) **Community Health Worker reimbursement**. Please use the table below to detail how Community Health Workers should be reimbursed:

Reimbursement process	(Please check all that apply)
Independently bill	☐
On staff (salary) at Primary Care Medical Provider Clinic	☐
On staff (salary) at RCCO	☐
Per Member Per Month Payment	☐

48) Oral health is an important part of overall health for both children and adults. Oral health benefits in Colorado are currently structured through an administrative services organization. What should be the RCCO's role in coordinating dental care and ensuring an adequate network of providers?

49) Cultural competence among providers is important to ensure a Client-centered, effective system that supports the health and well-being of clients and families.

k. What does cultural competence mean to you?

The ability to understand the client in the context of their culture. Cultural competence requires that organizations:

- have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.
- have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve.
- incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities.

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum. (adapted from Cross et al., 1989)

Move away from concept of competence since it is never fully achieved but move towards idea of cultural responsiveness.

l. What RCCO requirements would ensure cultural competency?

All providers in the system should have skills in cultural responsiveness. Culture should be a broad definition including such issues as sexuality like transgender etc.

m.

n. What skills must providers and staff have in order to provide culturally and linguistically-responsive care to all Clients/families including those with low health literacy?

We have a shortage of staff that are qualified to meet the needs of our deaf/hard of hearing clients.

o. Low heath literacy, different cultural health beliefs, and language barriers make communicating about health complicated. What RCCO requirements would help address these and reduce inequality in health outcomes?

This might be the area where community health workers and promotoras could be especially helpful. The RCCOS should have goals related to serving the demographics of their population.

50) Should the next RFP allow for preferred networks for specialty, facility, or ancillary care?

51) Nationally, rates of emergency room utilization are on the rise. This presents challenges in terms of cost and coordination of care. What should the ACC do to address this trend?

52) Please feel welcome to share other general advice, suggestions, and information you may have about network adequacy, PCMPs, specialists, pharmacies, or hospitals.

Practice Support

53) **Support for practices.** Please use the table below to describe the types of support RCCOs should offer to practices and other providers. Please check boxes to indicate if specific tools should be provided, and if the state, rather than the RCCOs, should offer a platform of support:

Type of support	Yes	No	Should a specific tool be required?	Should the state provide?
Administrative support	☐	☐	☐	☐
Network provider education	☐	☐	☐	☐
Assistance with practice redesign	☐	☐	☐	☐
Assistance with efficiency-enhancing activities	☐	☐	☐	☐
Provide web-based resources and directories	☐	☐	☐	☐
Provide practice-specific data reports	☐	☐	☐	☐
Provide clinical care guidelines and best practices.	☐	☐	☐	☐
Provide clinical screening tools	☒	☐	☒	☒
Provide health and functioning questionnaires	☒	☐	☒	☒
Provide chronic care templates	☐	☐	☐	☐
Provide registries	☒	☐	☐	☐
Offer client reminders	☐	☐	☐	☐
Offer client self-management tools	☐	☐	☐	☐
Offer educational materials about specific conditions	☐	☐	☐	☐
Supply behavioral health surveys	☒	☐	☒	☒
Supply other self-screening tools	☐	☐	☐	☐
Administer behavioral health surveys	☒	☐	☒	☐
Administer other self-screening tools	☐	☐	☐	☐
Prepare client action plans	☐	☐	☐	☐
Provide training on providing culturally-competent care	☒	☐	☐	☐
Provide training to supporting staff	☐	☐	☐	☐
Provide training on motivational interviewing	☒	☐	☐	☐
Provide tools and software for phone call and appointment tracking	☐	☐	☐	☐
Provide tools and resources for tracking labs, referrals, etc.	☐	☐	☐	☐
Provide referral and transitions of care checklists	☐	☐	☐	☐
Provide visit agendas or templates	☐	☐	☐	☐
Provide standing pharmacy order templates	☐	☐	☐	☐
Provide comprehensive directory of community resources	☐	☐	☐	☐
Provide directory of other resources	☐	☐	☐	☐
Provide materials regarding Nurse Advice Line	☐	☐	☐	☐
Ensure all tools and resources are centrally located on RCCO-specific website	☒	☐	☐	☐
Others	Should have common tools or a short list of tools in order to collect comparable data. Some suggestions include SBIRT; depression tools, trauma screening, developmental screens. Tools should be evidence based but allow room for additional questions or issues that might be a local			

Concern. Might be helpful to have behavioral health registries that could assist with care across providers such as prescription drug registry to prevent "doctor shopping" etc.

54) If you checked any of the boxes in the column entitled "should a specific tool be required" from the table above, please provide details about the specific process, tool, or product that should be required.

55) What RCCO requirements or services should be required to support practices in practice transformation or to assist practices in becoming more efficient and robust medical homes?

56) What is the most effective way to recognize and reimburse PCMPs based on their capacity to serve as a client's medical home?

57) Should the Department require that PCMPs utilize disease registries to manage the health of their population?

58) Please share any other advice or suggestions about provider support in the ACC.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

62) The Department is evaluating various financial and administrative arrangements that may involve licensure by the Division of Insurance (DOI). Licensure may require financial reserves or the fulfillment of other regulatory requirements. For potential RCCO bidders: is your organization licensed by the DOI with an LSLPN, HMO, or other license? Would the requirement to obtain a Limited Service Licensed Provider Network (LSLPN) license or a Health Maintenance Organization (HMO) license preclude your organization from bidding?

63) What role – if any – should the RCCOs play in the distribution of payments to providers?

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

66) **Measuring Client experience.** Please complete the table below to indicate how the Department should measure Client/patient experience:

Tool:	Should it be used? Yes	No	Comments:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	☐	☐	
SF-12 Health Survey	☐	☐	
Other types of client interviews / surveys	☐	☐	
Patient Activation Measure	☐	☐	
Focus groups	☐	☐	
Other	Please type your response here.		

67) Knowing that, at this time, the Department only has claims data, how should population health be measured?

68) How should quality and performance data be reported to the RCCOs, PCMPs, and the public?

69) **Measures for payment.** Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☐
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐
None	☐

70) What percent of RCCO payments should be tied to measures or performance?

Percentage	
10-20%	☐
21-30%	☐
31-40%	☐
41-50%	☐
51-60%	☐
61-70%	☐
71-80%	☐
81-90%	☐
91%+	☐

71) Should all RCCOs, across each region of the state, be paid on the same Key Performance Indicators (KPIs)? Should providers and RCCOs be paid on the same KPIs?

72) Should RCCOs be reimbursed based on their performance compared to national standards or based on improvement?

73) Should the Department only tie payment to measures where data can be provided on a monthly or regular basis (as opposed to annually or bi-annually)? This will mean that, for a period of time, we may be constrained to only tying payment to claims-based measures.

74) **Incentive payment frequency.** Please use the table below to answer how frequently the Department should make incentive payments:

Monthly	☐
Quarterly	☐
Annually	☐
Other	☐

If you checked the "Other" box, please describe payment frequency below:

75) For potential offerors and other similar organizations: please describe the fixed costs of operating a RCCO.

76) For practices and community providers, what are you currently measuring to assess the quality of your care delivery? Are you being reimbursed on any of these measures?

Health Information Technology (HIT)

77) **Types of communication.** For clients with Medicaid coverage, please use the table below to rank each by whether or not you would use it to communicate with your provider or RCCO:

Type of Communication	No, I wouldn't use	Yes, I would use
Phone call / phone number	☐	☐
Text message	☐	☐
Web portal	☐	☐
Email	☐	☐
Telemedicine / Video chat	☐	☐
Face-to-face meeting	☐	☐
Smartphone app	☐	☐
Other:		

78) **HIT investments by organizations.** For all organizations, including potential bidders, networks, practices, and others: the table below asks about what HIT your organization has invested in and what it plans to invest in over the next two years. Please complete the table below:

Tool	Own / Operate	Plan to Operate in next 2 years
Population analytics / reporting	☒	☒
Digital care management tool	☒	☒
Care transitions alerts	☐	☐
Electronic Health Records (EHRs)	☐	☐
Health risk assessment software	☐	☐
Practice assessment tools	☒	☒
Practice management tools (scheduling, billing)	☐	☐
Client web portal for communicating care plan, services, benefit enrollment	☒	☒
Patient education/wellness tools	☐	☐
Provider/case manager directory	☒	☒
Shared decision-making tools	☐	☐
Telemedicine software	☐	☐
Other:	☐	☐
Other:	☐	☐

79) **Importance of technology by type.** The Department is working to determine what technology is in place, what technology is needed, and what technology should be standardized. For RCCOs, providers, and other organizations, use the table below to answer what HIT infrastructure outside of the SDAC your organization would use to perform population health management activities. Tools are scored from 1-5, where 1 are those items least-likely to be used, and 5 are items most-likely to be used:

Tool	1 Least	2	3	4	5 Most
Population analytics / reporting / dashboard	☐	☐	☐	☐	☒
Care management tool	☐	☐	☐	☐	☒
Care transitions alerts	☐	☐	☐	☒	☐
Electronic Health Records (EHRs)	☐	☐	☐	☐	☒
Practice assessment tools	☐	☐	☐	☒	☐
Health risk assessment software	☐	☐	☐	☒	☐
Practice management tools (scheduling, billing)	☐	☐	☐	☒	☐
Client web portal for communicating care plan, services, benefit enrollment	☐	☐	☐	☒	☐
Patient education wellness tools	☐	☐	☒	☐	☐
Provider/case manager directory	☐	☐	☐	☒	☐
5hared decision-making tools	☐	☐	☒	☐	☐
Telemedicine	☐	☐	☒	☐	☐
Other:	☐	☐	☐	☐	☐

80) What are the primary barriers to RCCOs and providers increasing their use Health Information Technology to improve the performance of Primary Care Practices?

Technology costs and data standards.

81) How can Health Information Technology support Behavioral Health Integration?

OBH is currently revising their data system. The new system will be supportive of integration because it will comply with national data standards so that the system can be interoperable with provider electronic health records and other state systems. In addition the system is a modular one which allows for more flexibility in the information collected as well as the ability to review information in real time.

Some small providers especially SUD providers need incentives and help to upgrade their systems so they can participate with the electronic health records. There should be one set of metrics across systems.

82) In the next iteration of the ACC, should there be a shared resource for data and analytics? Please describe the basic criteria for what a shared data and analytics platform needs to contain in order for it to be useful.

Shared resources could be aided by an agreement on common tools, measures, and data standards. Common modules could be developed to capture information into one system or distribute common electronic information between separate systems. A single analytic tool working with a comprehensive statewide data warehouse would be an ideal solution for improved and timely information.

83) Should there be a shared care management tool? Please describe the basic criteria for what a care management tool would need to contain in order for it to be useful.

Yes-Ability to track client specific goals, ability to collect data from other systems; ability to connect to electronic health record; ability for multiple providers to enter data. The care management tool would need to track and properly measure mental health, substance use disorder and physical health needs and outcomes. The tool would also need to be flexible to adapt to the needs of different demographic groups, a primary example of this being various age groups. The most likely solution could be a set of shared management tools rather than just one tool for everyone.

84) Should there be a shared population health management tool? Please describe the basic criteria for what a population health management tool would need to contain in order for it to be useful.

A shared population health management tool must have a strong emphasis on prevention.

85) Please describe the functionality that a common Medicaid provider directory would need to contain in order for it to be useful.

It should include behavioral health providers, information about track record in treating specific conditions and specialty areas as commonly defined.

86) How can the RCCOs support providers' access to actionable and timely clinical data?

87) What are the HIT solutions that would benefit clients, providers, and RCCOs? Please comment on the parameters these tools or platforms would need to possess and the ways in which they could be used.

88) What technical assistance or resources related to HIT infrastructure should the RCCOs supply? This assistance or these resources could be for providers, social service organization, clients/families, or for others.

89) What role should health information exchange platforms like CORHIO or QHN play in the next iteration of the ACC?

CORHIO and QHN can be extremely useful by being a conduit of information for improving continuity of care across agencies and providing behavioral health providers critical health information such as hospital admissions, emergency department visits and prescription drug information. CORHIO also can play a vital role in patient identification for improved statewide episode of care tracking.

90) Please share any information, advice, and suggestions you have about health information technology in the ACC Program.

Colorado Department of Health Care Policy and Financing

RFI Response Received and Recorded.

Serial Number: 121

Accepted by: KJDW

Notes: Standard cover sheet added

REQUEST FOR INFORMATION

RFI UHAA 2015000017

Accountable Care Collaborative Request for Information

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

RESPONSE WORKSHEET

Basic Questions for All Respondents to this Request for Information:

Please provide your name and location:

Name: Michael Whistler

Location: Grand Junction, CO

If you are a member of (or affiliated with) an association, business, or other similar entity, please provide the name and location of that organization:

Name of organization: Western Colorado Pediatric Associates

Location: Grand Junction

☐ Please check if you are answering on behalf of this entity

Please choose the best description for you, your organization, or the person on the behalf of whom this response is being submitted – Check all that apply:

☐ Client
☐ Client's family member
☐ Client advocate
☒ Medical provider / PCMP / other provider
  i. Type or specialty:
  ii. Area of practice: General Pediatrics
☐ Provider advocate (e.g. medical society)
☐ Potential bidder for RCCO contract
☐ Behavioral Health Organization
☐ Data or HIT entity
☐ Foundation
☐ Educational or research institution
☐ Another public or private program
☐ Legislator or elected official
☒ Other (please describe): Advocate for children on Medicaid

How have you been involved in the ACC program and what interaction have you had with RCCOs:

Several years

Please briefly describe your involvement with Medicaid, either in Colorado or another state:

In Grand Junction, we were fortunate for several years to get Medicaid through RMHP. We were paid a very competitive rate. Over the last few years, the RMHP program has decrease the reimbursement for Medicaid, then just this last month RMHP Medicaid has been phased out completely. We have been accepting RCCO Medicaid since its inception.

Are you currently involved in the ACC program?

☒ Yes
☐ No
☐ I don't know

If you answered "yes" above, how long?

☐ Less than one year
☐ 1-2 years
☐ 2-3 years
☒ 3-4 years
☐ Since before the program was implemented.

If you are a client, provider, or potential bidder, what is the likelihood that you will seek to participate in the program?

☒ Very likely
☐ Likely
☐ Reserved (waiting to see the RFP)
☐ Unlikely without significant changes
☐ Will not seek to participate
☐ N/A

Our group is committed to caring for the Medicaid population, and to payment reform. We are ready to embrace any change that will allow us to continue to practice pediatrics.

General Questions

1) What is working best in the Accountable Care Collaborative (ACC) right now?

- Reimbursement (mostly due to the Federal ACA) is fairer now.
- The decision to make the well child visit one of the KPIs was a very good decision in behalf of children, but unfortunately attribution is still flawed and the SDAC data is delayed and often inaccurate. So, it is difficult to create an effective QI process to improve the KPI, but this is a good start.
- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.
- You have a great opportunity to do what is needed for the majority of Medicaid recipients. The majority of Medicaid recipients in Colorado are children and adolescents; they should

not be considered one of the subgroups. The following principles should be incorporated into the core objectives of the ACC:

- Children's health care needs are very different than adults. For adults, the focus is on managing chronic disease more effectively. For children, it is about preventing the development of those chronic diseases.
- If the ACC really wants to focus on health and wellness, the greatest opportunity is with the children (the majority of Medicaid recipients). By focusing on preventive care, early screening and early intervention for children, there will be big savings; unfortunately those savings may not occur for many years or decades in the future, but the investment will eventually be worth it.
- So, the ACC will need to invest in children to the extent possible now even though the savings come much later. We recommend that a portion of short-term savings that occurs due to chronic disease management in adults in the ACC be invested back into preventive care for children.
- Children are part of families and you can't help the child unless you help the family. So, care coordination is more involved for children since it includes care coordination of the parents/family.
- There is increased recognition that behavioral health is a part of overall health and should be accessible within a pediatric medical home. However, the current mental health system must have policies, procedures, and resources that support integrated behavioral health activities at the practice level. Barriers to paying mental health providers for seeing Medicaid patients should be decreased or eliminated.

2) What is not working well in the ACC Program?

- Attribution continues to attribute patients to the wrong medical home and the process of getting patients reassigned to the correct medical home is onerous for the patient and family.

- The health care data through the SDAC is based on claims so it is delayed and is incomplete (particularly for children). Therefore, it is not very useful in helping medical homes improve outcomes for children.

- Each RCCO does things very differently, which is confusing for medical homes with patients in several RCCOs. RCCOs are inconsistent in how they respond to requests for care coordination (quite variable depending on whom you reach at the RCCO). So the new RFP should ask how RCCOs will develop policies and procedures to make their methods and responses to requests for help more consistent, both within the RCCO and among all RCCOs.

- There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work for the medical home to adapt to the differences. To deal with this. So, the RFP should ask how RCCOs intend to

communicate and at least make an attempt at uniformity.

- If a patient lives in one region and goes to a medical home in another region, and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from the patient's region RCCO. This is particularly true in the Denver metro area. There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients.

- The "incentives" now are actually disincentives, especially the requirement that the RCCO must meet its KPIs before a high performing medical home can be rewarded for meeting its KPIs. The concept behind this approach is not consistent with how health care systems (and "medical neighborhoods") work.

- The geography of the 7 regions does not reflect the natural geography of health care systems and referral patterns. Larimer County should be in Region 2.

- RCCOs are not providing the level of care coordination that Medicaid patients need. We have had RCCO "care coordinators" just tell us to call 211. The level of commitment that patients and families need is difficult to find, unless care coordination is provided at the medical home level or the community level.

- Both family practices and pediatric practices report that the SDAC does not reflect their own data that the practice can obtain from their EHR or their own claims data. This is particularly true regarding data on health care screening. The RFP should ask how RCCOs and HCPF should take advantage of this practice-based data.

- Most medical homes are not working closely with RCCOs and are not receiving much support. The RFP should ask how RCCOs intend to work more closely with medical homes.

- Feedback from RCCOs to the medical home regarding patients referred to the RCCO for care coordination is spotty. How will RCCOs consistently provide feedback and communication to the medical home regarding what was done for the patients and whether there was improvement?

- There has been difficulty with communication from the state level through the RCCOs down to the individual practice/provider level. Providers feel as though they are not well informed from HCPF or RCCOs. We are grateful that CCHAP keeps us informed.

- The current system does not take into account the movement of patients on and off Medicaid and movement between RCCOs. Whether for KPIs or future shared savings incentives, practices need to be evaluated on established patients who have been in a practice for a minimum of six months. This allows the medical home to actually have time to make an impact on the child's care. Otherwise, it is a substantial disincentive for practices

to be open to the more complex and challenging patients, those that likely need access the most.

- Currently, there is very little communication and alignment between BHO's and RCCO's. In order for integrated behavioral health to be successful at the practice and community level, the BHO's and RCCO's must have similar goals, policies/procedures that are aligned, payment structures that are aligned with movement toward integration and ongoing close communication with one another. The RFP should ask how they intend to do this.

Behavioral Health Integration

7) What should be the next steps in behavioral health integration in Colorado?[1]

- The decision to focus on integrated behavioral health in medical homes is a wonderful decision to improve health outcomes for people covered by Medicaid. Thank you.

- If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. This would reduce duplication of efforts and have better alignment of incentives and payments that support integrated care.

- Open the behavioral health and wellness codes (96150 – 96155) now. Don't wait. This will encourage integration immediately and enable medical homes to start now the process of evolving toward full integration.

- Care coordination for both behavioral health and medical care should be done in the primary care setting. And either the RCCO and/or the BHO should delegate the responsibility to do care coordination and a pmpm to cover the expense to the medical home as part of the payment reform process. And behavioral health care coordination and medical care coordination needs to be fully reimbursed. In addition, the BHO and the RCCO will need to have information and care coordinators to assist medical homes to handle uncommon or very complex issues.

- If possible, funds to allow BHO and physicians to share an electroinc medical record should be made available.

- Provide infrastructure and funding for data collection and management to support integrated behavioral health in the medical home and the care coordination that will have to be part of that. Utilizing SDAC data is just one way to understand the activities within a medical home. SDAC data is delayed and does not include enough information to support behavioral health care coordination in the medical home. Other methods and technologies are needed. There will need to be an investment in the development of new technologies and methods to do behavioral screening, track referrals, document treatment and collect data on the whole care coordination process at the medical home level. This will require adequate reimbursement to cover the cost of starting up new care coordination programs in the medical home and start up technologies to improve screening, intervention and care coordination with follow through in the medical home.

- The CPACK program developed by CBHC is a very good program, particularly the following:
  a. Assistance with finding a behavioral health provider for patients
  b. Telephone consultation by a child psychiatrist to primary care providers
  We recommend that BHOs be required to provide the 2 components above as part of their new contracts.

- Payment options for integrated behavioral health (not just co-location) need to be clear and understandable to providers and practices. In order for the integrated model to be sustainable, there need to be ways to access understandable billing rules/policies.

Care Caordinatian

Question 12) What needs far children/families shauld be caardinated in medical hames and are there services that shauld nat be a part af care caardinatian by the pediatric and family medical hame

One of the most difficult services to provide in the medical home is home visits. Support from the larger system is needed.

Services that can be provided in a pediatric or family medical home are: complex medical coordination including logistics/travel, ancillary services (PT/OT/home health services, ...), collaboration with mental/behavioral health, collaboration regarding school needs, referrals to early intervention services and Child Find, referral to other agencies (rehab, hospice, ...), collaboration with foster care and DHS system. RCCOs need to help medical homes with needs like assistance with housing, food, parental employment, child care, in which case the RCCO can help families connect with other agencies that provide these services.

Question 19: How should care coordination program be evaluated? How should its outcomes be measured?

A care coordination program should initially be measured by having good processes, not measured by outcomes, until solid data exists on outcomes that are risk adjusted and accurate for children. Initially all measures need to be quite separated from outcomes that are highly tied to patient behavior, or practices will again be less likely to serve those with highest risk.

23) Please share any other general advice or suggestions you have about care coordination in the ACC.

For those medical homes that relate to multiple RCCOs should be delegated to do care coordination. If all RCCOs allowed medical homes to be delegated to do care coordination, we could receive a pmpm from all of them, which would enable us to afford to hire enough care coordinators to meet the needs of all of our ACC patients.

Where should care coordination be done? Care coordination is best done in the medical home. We are willing to do care coordination, because we have a relationship with our patients and they trust us and we recognize that coordinating complex medical care is essential for good care and for cost savings. Also, the primary care provider is best positioned to have a long term relationship with the patient, and therefore know and understand other aspects of the patient's life and how important those non-medical factors are on the patient's health and health issues.

If care coordination cannot be done in the medical home, then it is best done by community-based organizations. The least effective, least well-received, least trusted is care coordination done from a call center in an RCCO. The role of the RCCO should be to help the medical home-based care coordination staff access resources for families.

The majority of practices are willing to provide Care Coordination, if they can get financial support (PMPM) for providing the service.

Should you be doing care coordination for certain patient populations e.g. children with asthma or special needs children? Or for your entire Medicaid population healthy or chronically ill? The overall goal of Colorado Medicaid should be to provide care coordination services for ALL patients in the Medicaid population (for some patients it may be very minimal, others extensive). This is the essence of preventive care. A care coordinator that is based in the medical home is in the best position to help identify risk factors proactively, as early as possible before they impact a patient's health and cause illness. Children with special healthcare needs (complex, complicated) require a higher level of care coordination, so the pmpm attached to their care coordination needs to be risk adjusted.

Program Structure

24) If you could require all RCCOs to implement certain functions in the same way across the state (or across all regions), what functions would you consider most important? (The

Department has heard examples such as: care coordination requirements, data reporting to the RCCOs, data reporting from the RCCOs, provider contracting, and payment methodologies).

- All RCCOs should have their offices in the region served, should be non-profits, be a Medicaid provider and be incorporated only in Colorado.

- All RCCOs should offer to delegate care coordination to medical homes willing to accept that responsibility and the RCCO should share a portion of the RCCO pmpm with the medical home that accepts delegation.

- All RCCOs should use the same criteria for delegation and for the amount that is paid for delegated services of care coordination. By doing this, services can reach a standard across the state. A patient would have access to similar services no matter where they moved across Colorado.

- RCCOs should all agree on how they will effectively communicate to medical homes regarding any contact the RCCO has with patients attributed to the medical home. They should include PCMPs in developing those criteria.

- All RCCOs should help (or contract with an organization to help) medical homes understand how to access their SDAC data, understand their data and use it to develop rapid cycle QI projects to improve health outcomes and meet KPIs.

- All RCCOs should agree to provide uniform support for medical homes when a medical home asks for help with care coordination, even when the medical home is in another region (and contracted with another RCCO) but the patient is in the first RCCO's region.

- RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels is their patients and receive help from the RCCO to understand why certain patients have been attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

- RCCOs should share on a regular basis the RCCO's performance on KPIs and share savings incentives and share with the medical home how their own performance compares with other medical homes.

26) The Department has received suggestions that, in the next RFP, PCMPs should be allowed to choose the RCCO to which that practice's clients are enrolled. Please comment on this proposal.

This is particularly applicable to the Denver metro area. In our Region, it does not make sense to include Larimer county.

27) Should the RCCO region maps change? Why or why not? If so, how?

Yes. There are two changes we recommend:

- Larimer County should be included in Region 2, since the medical community and the support organizations of Larimer County and very closely linked to Weld County
- In the Metro Denver area, the boundary issues are so difficult that we recommend one RCCO be responsible for the whole metro area or that medical homes be allowed to choose one RCCO for all of their patients.

28) Should the BHO region maps change? Why or why not? If so, how?

If Colorado is serious about promoting integration of behavioral and physical (medical) health care, then the RCCOs and BHOs should be integrated. This would mean they should have the same regions and function as though they are one organization. They should share incentives that are aligned around successful integration of behavioral and medical services and outcomes. So the BHO maps/regions should conform to the RCCO regions/maps.

32) Should there be multiple RCCOs per region? This would involve two or more entities operating in the same region and competing for clients and providers. If so, why? If so, how many and where? What issues would this address?

There should be one RCCO for the metro area or medical homes should be allowed to select one RCCO for all of their ACC patients. There are certain expectations/requirements and ways of doing things that are so different from one RCCO to another that it requires significant extra work to adapt to the differences. If a patient lives in one region and goes to a medical home in another region and the medical home is not contracted with the RCCO for the region in which the patient lives, it is difficult to get help from that first region. This is particularly true in the Denver metro area.

Another alternative: When a practice contracts with a RCCO currently they "belong" to one RCCO. Change that and have them only contract with the state and have that contract extend to all RCCOS. This way RCCOS would be more accountable to standardization through out all of Colorado, and the services provided to patients/families would be more uniform.

34) What role should RCCOs play in attributing clients to their respective PCMPs?

The attribution system is quite flawed still. RCCOs should be required to allow medical homes to give the RCCO a list of patients the medical home feels are their patients and receive help from the RCCO to understand why certain patients are attributed to another medical home. If the patient is determined to be more appropriately attributed to the inquiring medical home, then the RCCO should help re-attribute the patient to the correct medical home.

Payment Structure and Quality Monitoring

59) Does the current payment structure support the goals of the ACC? How can financial incentives be further aligned to support these goals?

- The payment structure absolutely does not support the ACC goals. A medical home does not receive incentives for KPIs unless the RCCO meets its KPI. This becomes a disincentive, because many medical homes meet their performance targets, but do not get rewarded because the RCCO did not meet its targets. So the medical home has no incentive to maintain the performance. The philosophy that HCPF has espoused (that the high performing medical home should encourage or help the low performing medical home) is not realistic and is not how the real world works. There is no time for that, plus the high performing medical home has no way of knowing who is low performing. This idea shows a lack of understanding of the world where health cares is delivered. Medical homes need to receive full incentives when they meet their KPI targets, no matter what happens in the RCCO.

- The incentives are too low to change much. Also, the KPIs need to remain focused on process, not outcomes, until the data is more sophisticated to accurately attribute patients and account for risk factors.

- Many medical homes have the ability to collect REAL-TIME data from their EHR and their claims database, which can be used to measure performance more accurately than the SDAC. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust the medical home self-reported real-time data.

- Since children are the majority and give the best chance of truly improving health and wellness, KPIs need to be more child-focused. And since the potential cost savings for children's health care are so far in the future, KPIs need to be intermediate, process outcomes.

60) If PCMPs could voluntarily elect to receive capitation payments rather than fee-for-service, would your practice be interested in participating? Under what parameters? What services should be included in a primary care capitation?

<u>There is very little of the infrastructure in the state in place at the present time to enable capitation to be implemented successfully.</u> Here are just some of the changes that would need to be in place before it would be fair or prudent to implement capitation:

- The state would need to already be paying fair amounts for all aspects of the care needed by Medicaid recipients before it could effectively move to capitation. In other words, codes for things that HCPF wants done under capitation should be opened and reimbursement adequately now. This would encourage medical homes to already be doing these things before the change to capitation. It would also give HCPF and medical homes experience regarding what the actual costs are for providing the desired services and determine a fair capitation. It will be difficult to change behavior to include new activities under capitation among providers, if you continue to hold codes closed now for things you want done under capitation. You have to help the medical homes create the habits you want before the switch to capitation.

- All providers would have to be reliably involved in the ACC: primary care, all of the various adult and child specialists, the hospitals, the therapies, dentists, mental health providers, etc. Access to specialty care is vital, but could be included in a global payment structure.

- The data system would have to be able to report real time data and be far, far more accurate than it is now.

- The attribution system is flawed. That would have to be improved and provide accurate, real-time attribution data before capitation should be instituted.

- You will have to change a variety of policies that are barriers to population management.

- Capitation has to be combined with significant incentives to implement processes and improve outcomes. So, you will need to have the incentive system very well developed and viewed by providers as motivating before implementing capitation

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

- Early in the transition from pre-ACC payment methods to ACC payment structure (2012), some medical homes were asked to return money to Medicaid. Transitions like that (for example the transition to capitation) have to avoid this. Primary care medical homes have such narrow margins that this can be very difficult financially on a medical home

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a

timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and providers to develop a vetting process that will enable HCPF and RCCOs to trust that medical home self-reported real-time data is trustworthy.

61) Do providers have the infrastructure to be successful in an environment where payments are tied to value? If not, what are the barriers to developing that infrastructure?

Many medical homes have the capability and infrastructure to adapt to payment tied to value. What is missing is the state, HCPF, RCCO, BHO infrastructure. See all of the infrastructure elements HCPF needs to have in place listed in question 60

64) Please feel welcome to add any further thoughts or suggestions pertaining to payment reform within the ACC.

- The HCPF Payment Reform Committee should meet at a time when providers and practice managers can actually attend. Monday afternoons is probably the worst time to actually enable providers or practice managers to attend. Once you select an appropriate time, then actively recruit participation.

- Make sure that your efforts are statewide. Views are different in the various regions of the state.

65) What types of measures should be tied to payment in order to ensure the program improves the quality of care, satisfaction of clients and providers, and health outcomes?

- Many medical homes have the ability to collect from their EHR and their claims database REAL-TIME data with which performance can be measured. HCPF, SDAC (Treo Solutions), CIVHC, and RCCOs only have Medicaid claims data, which is far too delayed to be useful for medical homes to use to do rapid cycle quality improvement to improve performance in a timely manner. Therefore, HCPF and RCCOs will have to use data self-reported from medical homes to obtain real-time, useable data. This requires that HCPF and RCCOs work closely with representative practice managers and provider from medical homes to develop a vetting process that will enable HCPF and RCCOs to trust medical home self-reported real-time data.

- The measures for children can be drawn from HEDIS measures or CHIPRA measures or from the Pediatric Measurement Proposal that HCPF did in 2010 with the help of Jim Todd. Appropriate child health measures could be selected from the following measures :
  - Well child visits appropriate for age
  - Developmental screening by three years of age
  - Teen depression screening
  - Complete immunization status by age two

- Post-partum depression screening rate for mothers of newborns by age 4 months
- Appropriate antibiotic use in URI and strep pharyngitis

- Medical homes could also be measured on:
  - Patient (or family) satisfaction ratings
  - Documentation of QI projects

Screening should be part of KPIs, but you need to do more than just create a KPI. If you are going to have KPIs, then you need to track not only the number of times a screening was done, but also track the v-codes (or some way to track positives) and make them available in the SDAC so medical homes can track them. And the SDAC needs to track referrals (or intervention). Otherwise it is not worth measuring the number of screenings.

- The PCMP or medical home should receive real-time data (less than a month since date of service) with data that will allow them to compare their performance with performance of similar type of medical home.

- Healthcare for children focuses on prevention, early detection and early intervention, which require initial increased investment to reduce potential expenses many years and decades down the line. Other ACO programs have shown that savings on children are difficult to show early on. So, incentives in the care of children will initially be for intermediate outcomes (or for process outcomes) and need to be direct incentives rather than incentives in the form of shared savings.

69) Measures for payment. Please use the table below to describe how many measures should be tied to payment at one time. These could function similarly to Key Performance Indicators, but they do not necessarily have to do so. Please assume that the Department will try to align measures with other programs to the extent possible.

Measures	
1-7	☒
8-10	☐
11-20	☐
21-30	☐
31-40	☐
41-50	☐
51+	☐

None	☐

We only need 2-4 KPIs. Any more will dilute the effect. What we really want is good data, so we can improve our outcomes by doing a quality improvement project. Since children are the majority of Medicaid recipients and give you the best chance of truly improving health and wellness in the long term, KPIs need to be more child-focused. And since the savings are so far in the future, KPIs need to be intermediate, process outcomes.