

**State of Colorado
Department of Health Care Policy and Financing
Request for Information**



RFI # HCPFKQ1001RFIACC

Accountable Care Collaborative

**THIS IS A REQUEST FOR INFORMATION (RFI) ONLY AND IS
NOT A FORMAL SOLICITATION.
NO AWARD WILL RESULT FROM THIS RFI.**

July 15, 2009

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1. Purpose

The Department is issuing this Request for Information (RFI) to:

1. Receive feedback on the Department's initial design; and
2. Gauge stakeholder interest in participating in a new Administrative Services Organization (ASO)/Enhanced Primary Care Case Management (ePCCM) delivery system.

The Department seeks to promote a client-centered, outcomes-focused system of care that affordably maximizes the health, functioning and self-sufficiency of clients. An outgrowth of Governor Ritter's *Colorado Promise*, the title of this project is the Colorado Accountable Care Collaborative.¹ It is one of several concurrent initiatives in Medicaid reform.

This RFI is not a solicitation for products and/or services and will not result in an award or contract. However, the information collected from this RFI will be used to further refine the Department's current model, to modify the model, and to guide in the drafting of the soon-to-follow Requests for Proposals (RFPs).

The Department is soliciting information from interested parties including: client groups, community and statewide social service organizations, local governments, independent physician associations (IPAs), physicians, hospital systems, providers, provider collaboratives, managed care organizations, health plans, clients, quality organizations, health foundations and any other interested party capable of assisting the Department to meet its objectives. Information submitted by an interested party is voluntary and with the understanding that this RFI is for information gathering purposes only and is not a formal solicitation.

Several RFPs are anticipated to be issued after the Department has had an opportunity to review the information submitted in response to this RFI.

2. Who Should Respond

The Department encourages anyone with an interest in the Accountable Care Collaborative model to respond. Organizations that are considering submitting a proposal for the regional entity contracts are encouraged to collaborate with the local providers and regional centers of excellence located in those areas when submitting a response in order to illustrate how the possible future collaboration might work. Interested providers (individual physicians, physician practices or clinics) are also encouraged to respond. The Department is interested in receiving "best in breed" solutions that showcase both value and innovation.

3. Sectional Layout of the RFI and Targeted Questions

The RFI is organized as follows:

1. Information regarding the Request for Information.
2. Background, Goals, Objectives and Overview of the Accountable Care Collaborative.
3. Program Inquiries.
4. Compensation Inquiries.
5. Glossary (see Page 48).

¹ It will be renamed and formally branded before implementation.

The Program Inquiries section is broken into sections that are targeted to specific identified groups or persons. This division was made for the convenience of responders who otherwise might find the RFI too daunting, but who might be willing to spend the time to answer a smaller fraction of the total. However, responders are not limited to answering only the questions posed directly to them. Any responder is free to answer any or all questions regardless of their sectional placement.

Some functions or descriptions in the following sections may have a “**DAY ONE**” notation. This notation indicates base functionality that a contractor would need to be able to provide at program inception in July 2010.

Call out boxes like this one will appear throughout the RFI with commentary, additional program designs, or model add-ons. The ideas and concepts contained in the call-out boxes are not necessarily part of the Accountable Care Collaborative design, but they might be depending upon resources and respondent feedback. After each call-out box will be questions addressing the ideas expressed therein.

4. Response Criteria

The Department is seeking information from stakeholders, providers, vendors, and interested parties to obtain recommendations regarding processes and best practices to organize and implement a regional collaborative care model for Colorado’s Medicaid program.

Interested parties are requested to use the response format supplied in Appendix A and to submit their responses electronically, if possible, with the following characteristics:

- In Microsoft Word, if sent electronically. If sent as hard copy, letter-sized (8-1/2” x 11”) paper
- 12-point font or larger
- Page numbers on each page
- All respondents should respond to the questions in Section 15.1
- Include the section letter, number, and the complete text of each question to which you are responding. (Responses can be limited to questions and areas of interest and parties are not required to complete all sections and questions contained in this RFI.)

5. Disclosure of Responses

The Department reserves the right to disclose the information submitted in response to this RFI to Department and state employees, and some or all of the information may be posted publicly. Any requests for confidentiality or restrictions on the use or inspection of the materials submitted in response to this RFI will not be honored. All materials shall be available to the public, upon request, pursuant to Title 24, Article 72, Colorado Revised Statutes.

6. Inquiries

For questions or clarifications regarding the RFI or the program, please submit your inquiries in writing to Katherine Quinby. The preferred method is via email. You may also fax inquiries to Katherine Quinby. Inquiries will be accepted until July 29, 2009. Please submit your inquiries by that date. The Department will make every effort to respond to the inquiries as quickly as possible. Responses will be posted on the BIDS Website.

Contact Information for Katherine Quinby is as follows:

E-mail: katherine.quinby@state.co.us
Fax No: (303) 866-4411

7. Schedule

The schedule for the RFI is as follows:

RFI Release Date	July 15, 2009
Inquiries Regarding the RFI Accepted Until	July 29, 2009
Expected Department Responses to Inquiries Regarding the RFI	August 5, 2009
RFI Submission Due Date	August 14, 2009

Please note that early responses are appreciated. Responses received by close of business on August 14, 2009 will be considered by the Department. Late responses may be submitted, but the Department may not be able to integrate them into its planning and decision-making process.

After the RFI response period has ended, the Department will compile and post the responses received on the Department's website.

8. Submission Instructions

The Department will gladly accept responses anytime through the submission due date identified in the **Error! Reference source not found.** section of this RFI.

Respondents are requested to submit their responses electronically. Electronic submissions in Microsoft Word format are preferred. Alternatively, submissions in PDF format are acceptable. Please include RFI No. HCPFKQ1001RFIACC in the subject line.

Respondents may submit their responses in hard copy. If submitting hard copies, please provide three (3) copies of your response. Please label the outside of your mailing package with RFI No. HCPFKQ1001RFIACC.

Submit your responses to:

Katherine Quinby

Department of Health Care Policy and Financing
Contracts and Purchasing Section
1570 Grant Street
Denver, CO 80203
Phone: (303) 866-4940
Fax: (303) 866-4411
E-mail: katherine.quinby@state.co.us

9. About the Department

The Department is the single state agency that operates the Colorado Medicaid program in accordance with the Colorado Medical Assistance Act (C.R.S. 25.5-4-101, *et seq.*) and Title XIX of the Social Security Act. The Colorado Medicaid program provides a wide range of physical, behavioral, and long term care services for Members in the fee-for-service (FFS) setting and for those enrolled in managed care. The Colorado Medicaid program is annually funded from appropriations authorized by the Colorado General Assembly and matched by federal funds. As of February, 2009, 440,274 clients were enrolled with Medicaid.

10. Overview of Colorado's Medicaid Program

Colorado Medicaid pays over \$2.4 billion per year in reimbursements to over 22,000 health care providers for medical and medically-related services and supplies. Health care providers who submit claims under Medicaid are reimbursed for physician services, hospital care, prescriptions, nursing facility care, home health care services, and a variety of other medically necessary health care services, which are rendered to eligible and enrolled Medicaid clients.

For more information on Colorado Medicaid, please review information available on the Department's Website — Colorado.gov/hcpf.

11. Client Volumes and Measures to Support RFI Responses

State Fiscal Year	Total Medicaid Expenditure	Emergency Room Expenditure	Inpatient Hospital Expenditure
05/06	\$1,982,396,076	\$37,199,872	\$307,791,009
06/07	\$2,048,437,415	\$43,537,006	\$316,652,856
07/08	\$2,227,037,481	\$49,181,697	\$325,970,428

2008 ER Visit claims	823/1000 FTE members
2008 Hospitalizations	194/1000 FTE members
2008 Inpatient Readmission Rates	5.29 at 7 days 12.59% at 30 days 20.34% at 90 days

Prevention Quality Indicator Name	CO Medicaid Rate Per 100,000*
DIABETES SHORT TRM COMPLICATN	152.51
PERFORATED APPENDIX	31.25
DIABETES LONG TERM COMPLICATN	244.13
COPD	370.39
HYPERTENSION	67.04
CONGESTIVE HEART FAILURE	430.16
LOW BIRTH WEIGHT	11.29
DEHYDRATION	137.43
BACTERIAL PNEUMONIA	763.68
URINARY INFECTION	405.58
ANGINA	20.11
DIABETES UNCONTROLLED	26.26
ADULT ASTHMA	198.32
LOWER EXTREMITY AMPUTATION	59.78
OVERALL PQI	2812.25
ACUTE PQI	1306.68
CHRONIC PQI	1506.12

*Rates per 100,000 except for Perforated Appendix and Low Birth Weight (per 100).

12. Background

The Colorado Department of Health Care Policy and Financing (Department) operates the Medicaid program and State Children's Health Insurance Program, administers the Colorado Indigent Care Program, and provides statewide health policy leadership for the Executive branch. The mission of the Department is to improve access to cost-effective, quality health care services for Coloradans. The Department seeks to modernize its physical health programs through a series of initiatives and the Accountable Care Collaborative is one designed to affordably optimize client health, functioning and self-sufficiency through promotion of regional collaboratives given flexibility and support to achieve common objectives.

The Department has a long history of innovation and service to improve access and health for served clients. Colorado leads the nation in the number of home and community based services waivers designed to promote alternatives to institutional settings of care for clients with complex needs. Furthermore, Colorado has innovative Community Transition Services and Client Directed Attendant Services designed to facilitate and support clients in the least restrictive setting of care. Low income children have benefited from SB07-211 which called for the establishment of a Patient Centered Medical Home for all children by 2010. This bill was augmented by a Performance Management Advisory Group (PMAG) that developed twenty-five benchmark performance standards to promote excellent care and outcomes for vulnerable children. The Department has also initiated a novel managed care program for adults with disabilities, the Colorado Regional Integrated Care Coordination Initiative, which promotes a medical home and care coordination. In addition, the Department has had several years of experience with an administrative services contract for the provision of physical health services on the Western Slope designed to provide gain sharing with physicians for demonstrating improved outcomes. Care coordination initiatives are underway across the state linking behavioral health and physical health with models of co-location as well as care plan communication.

While innovation serving vulnerable clients continues in Colorado, national initiatives are also underway that seek to optimize client health while promoting coordinated services, outcomes based payment, and the establishment of the medical home. Of key importance, four primary care physician specialties, the American Academy of Pediatrics, American Academy of Family Physicians, the American Osteopathic Association, and the American College of Physicians, have collaborated along with states and employers to promote the Patient Centered Primary Care Collaborative. The Collaborative has set forth principles of reform and is testing innovations across the country, including a pilot in Colorado. In parallel, Dr. Elliott Fisher has articulated an advanced model of care, the Accountable Care Organization, which recognizes the regional nature of health care delivery and promotes a local model of accountability for health and health care resource optimization. A more systematic model of reform has been articulated by the Institute for Healthcare Improvement's "Triple Aim" which calls for simultaneous maximization of population health, client satisfaction, and cost control. This model is complemented by the MacColl Institute's "It Takes a Region" which promotes value through parallel reform efforts in financing, delivery, client empowerment, and information exchange and management.

As the Department has worked to initiate the design of the Accountable Care Collaborative, it has looked at other states for new models that integrate patient-centered care for those facing chronic illnesses and consider an individual's environment and health behaviors and how those factors play a major role in the health of the population. The models of the states of Vermont and Wisconsin have had an impact on the vision of the Accountable Care Collaborative.

The Blueprint for Health is Vermont's response for improving the quality of care and quality of life for individuals with chronic disease. The Blueprint focuses on the multidimensional aspects of chronic disease prevention and management, and provides the information and tools for providers, consumers and communities to become empowered participants in improving individual and population health. The model also underscores the critical need for information technology tools and population based outcomes management. The model focuses on the areas of self-management, proactive provider practices, information technology decision support tools, community partnerships, and health system care coordination.

For six years the University of Wisconsin Population Health Institute (UWPHI) has completed the Wisconsin County Health Rankings. The rankings are designed to summarize the current health of the counties, as well as the distribution of key factors that determine future health. By taking a broad perspective on the factors that influence health—health care, health behaviors, socioeconomic factors, and the physical environment—the UWPHI seeks to encourage all community stakeholders to work with health departments and health care providers as partners in the public health system.

While reform efforts are underway to improve effectiveness and efficiency on health care delivery, another set of health efforts have been long established focusing on the health status of populations. *Healthy People 2010* provides national health objectives and identifies preventable threats to morbidity and mortality. The World Health Organization historically developed an evaluation of nation's health system attainment by evaluating disability adjusted life expectancy, responsiveness, per capita health expenditures and other metrics. Foundations including the United Health Foundation and Commonwealth Fund have been promoting health scorecards and rankings of health status, access, and affordability. The Dartmouth Atlas also highlights regional variation in care patterns. The National Quality Forum and the Healthcare Effectiveness Data and Information Set (HEDIS) have helped contribute to a culture of system evaluation and focus on quality largely on quality process measures within the delivery system.

The Accountable Care Collaborative aims to link actual achievement of improved health outcomes as reflected by functional, morbidity and mortality goals and healthy behaviors such as obesity rates, tobacco use rates with improvement in the delivery of health care services. The Department recognizes that optimization of these twin goals is complex, interdependent, and novel. The Department spends over \$4,000,000,000 per year on Medicaid services and intends to increasingly demonstrate to clients and taxpayers that these expenditures are not to be judged only by the volume of services but also by the outcomes they achieve.

As the Department considers its reform efforts, these Colorado and national initiatives, experiences, and models have played important roles in shaping this model. We encourage potential responders to familiarize themselves with these references to better understand the Department's perspective and offer their own viewpoints.

13. Goals and Objectives

The Department's goal for the Accountable Care Collaborative is to maximize the health, functioning and self-sufficiency of clients affordably. The Department envisions regional areas of accountability by adding new provider and client support services, sophisticated data analysis capabilities, outcomes-focused contracting, health information technology services and gain sharing provisions. The Department's core expectations include:

1. Assure that every enrolled client has a medical home that emphasizes a whole-person, client-centered focal point of care (i.e. extending the current children's Medical Home model to clients in all covered eligibility categories)

2. Maximize client health and wellbeing; functional status, and self-sufficiency;
3. Reduce avoidable and inappropriate health care resource utilization
4. Coordinate care across care settings including but not limited to transitions from hospital to community, specialist to primary care, youth to adulthood, and across physical, behavioral and long term care settings.
5. Measurably improve healthy behaviors and lifestyles
6. Promote, as appropriate and relevant, evidence-based and evidence-guided care;
7. Minimize the variability in care related to preference sensitive conditions, ambulatory care sensitive conditions and supply sensitive care;
8. Find ways to achieve value-based, cost-effective care;
9. Achieve a sustainable per capita cost of care
10. Encourage the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data;
11. Encourage the adoption of Electronic Health Record (EHR) technology to promote health care quality and the exchange of health care information;
12. Integrate information from Department and other health-related program areas into a single, unified data warehouse environment.

It is envisioned that the regional entities will act as “macro integrators.”² As Dr. Fisher describes, the: “macro integrator is not necessarily a new structure or a single organization but rather an entity that can pull together the resources of numerous organizations to form a virtual system to support a defined population and make sure that the system is optimized for the sake of the defined population. The most successful systems will find ways to link organizations across the continuum of care. Some specific functions of the macro integrator include providing the system with access to up-to-date medical knowledge and evidence about effectiveness of care and establishing standard definitions and measures of quality and cost. It makes the performance of the whole system transparent to those who pay for it and those who use it. The macro integrator works with and helps improve the frontline systems such as primary care providers, specialty services, hospitals and long-term care facilities that support individuals.”

One key aspect of the Accountable Care Collaborative is to build upon the Medical Homes for Children program that the Department has been implementing over the past several years, and it seeks to extend that program’s successes and core principles to other eligibility categories. The Accountable Care Collaborative builds upon this initiative by promoting coordinated collaboration with all providers, social services, local and state governments, advocacy and client service organization that interact to provide care and services to clients. Furthermore, the Department seeks to have a regional entity which will be responsible for achieving health, healthcare, and cost outcomes. By integrating the Medical Home for Children into the Accountable Care Collaborative, the Department is providing a more sustainable model for financial, administrative, and technical support for this initiative.

² The micro integrator is the person or team that makes sure the best and most appropriate care is provided to individuals and families. In effect, many practitioners act as their own micro integrators. A primary care team or “medical home” could fulfill this role as well, and there are likely to be other workable approaches to micro integration.

The Department intends to begin the Accountable Care Collaborative program in early Fiscal Year 2010, with the first client enrollments occurring in July 2010. The first fifteen months of the program will be limited to a maximum enrollment of 60,000 clients. As regions demonstrate success, expansion would occur in that region. Current caseload is 440,000 clients and expected to grow by over 10% by July, 2010. If five regions are decided upon, we estimate that each region will have 100,000 clients to serve.

the Department intends to foster meaningful delegation to local primary care providers similar to what was developed in the Oklahoma, Alabama, and North Carolina Medicaid reform models while building upon the Administrative Services Organization's accountability for performance and outcomes in the South Carolina, Indiana and New Hampshire Medicaid models.

The Department, in collaboration with stakeholders, will determine statewide standardized performance metrics. The regional entities, in collaboration with their providers and stakeholders, are expected to determine how to achieve them (with the support of the statewide Data and HIT entity and the Department.) Wherever possible, outcomes will be tied financially to the goals so that success is rewarded.

The Accountable Care Collaborative is purposely envisioned to be an evolving model. Certain attributes or goals are seen clearly. Many others will be discovered after implementation, and be solved by the perseverance of the regional entities, providers and clients who are "accountable" for program outcomes. The Department will retain authority over "what" the program is and does, subject to continuous collaborative feedback from all stakeholders. The regional entities and, to a lesser extent, the statewide Data and HIT entity, will be responsible for "how" to accomplish the Department adopted goals and standards, with these entities also subject to continuous collaborative feedback from all stakeholders.

Long-term, the Department would like to begin the conversation with all interested parties on how to better integrate the many federal, state and local programs into a more cohesive and efficient delivery system. Some concrete deliverables must be up and running by the time of the first client enrollments and are identified in this RFI as **DAY ONE** expectations. Other deliverables would come on later in the year, still others are conceptual and will need a lot of work by regional entities, providers and stakeholders to flesh out what they look like and how to create them.

The Department desires to leverage its existing strong relationships with clients, government partners, providers, Federally Qualified Health Centers (FQHC), and other stakeholders. Existing local networks of excellence would not be supplanted or marginalized by the regional entities; instead the Department seeks to promote regional models of coordination, communication, innovation and accountability by promoting existing entities and networks. The Department is soliciting input through this RFI to minimize potential barriers to participation.

The Department will strive to use contracts that manage to results and which allow best practice market-driven organizations the autonomy to achieve those goals with clear performance standards and requirements.

The Department is interested in attracting new providers into the Medicaid provider network and/or encouraging existing Medicaid providers to accept more clients.

14. Program Overview

The Accountable Care Collaborative program is made of up four parts: (1) regional entities; (2) a statewide Data and IT entity; (3) an evaluation component and (4) a centralized policymaking and administration function retained in the Department.

Client Perspective

Clients in the current fee-for-service system have intermittent and incomplete access to care coordination and community health education services. Clients also have difficulty accessing specialty care, in particular, and sometimes primary care as well. Care is provided by multiple providers and agencies with limited communication or coordination and clients and their caregivers have to traverse a bewildering array of fragmented systems of care. Furthermore, the current model of health care financing and delivery incents and rewards treatment of sickness rather than promotion of health. Providers are further financially incented to provide more services rather than financially incented to appropriate services or to achieve health. Medicaid also provides services to many eligibility categories whose health and social needs differ dramatically. Adults with disabilities, elderly dual-eligible clients, clients in foster care, low income children and caregivers all differ in the distribution of risk factors, co-morbidities, and predominant settings of care. The Department seeks as its first priority to maximize the health, functioning and self-sufficiency of covered clients recognizing the diverse needs of its distinct populations by eligibility, region, age, special needs and ethnicity. The Department intends to translate its expenditures for health care services into demonstrations of improved collective and individual client health. The Department fully recognizes that this paradigm shift from healthcare to health will require time, support, input, and incentives.

The ACC looks to transform the client experience with public insurance to one that is client-centered, promotes longitudinal care, helps clients navigate across complex systems, promotes their health, functioning and self-sufficiency, embraces social and cultural differences, advances shared and informed decision making, and treats clients and their caregivers with dignity and respect.

The Performance Metric Advisory Group output, *Healthy People 2010*, the CDC's Behavioral Risk Factor Surveillance System, Commonwealth Fund's State Scorecard, Kaiser Family Foundation State Survey and other efforts put forth metrics and goals for population health and quality of care. The Department anticipates working with shareholders to finalize a set of metrics to gauge health status, timely access to care, healthcare utilization and satisfaction of care. These common metrics would be used for all regions with regional flexibility on how to accomplish and exceed expectations.

The Department is contemplating that all Medicaid client aid categories would be eligible for enrollment. Enrollment will be automated as follows:

- For the purposes of the pilot period, the Department will not disrupt any client and/or provider enrollment in existing programs, such as the Medical Home for Children program. If the Accountable Care Collaborative pilot proves successful, these two efforts will be melded into one complementary program and not exist as competing or conflicting programs.
- Children enrolled in the Medical Home for Children program will not be enrolled into the Accountable Care Collaborative during the pilot unless and until their existing medical home physician chooses to join the program. When the physician joins the program, all of his or her Medical Home children would be enrolled into the program

and would be assigned back to the physician as the designated PCMP. From the point of view of the child and the child's family, the enrollment would appear to be seamless. The parents would also be able to exercise the same disenrollment rights as adults enrolled into the program.

- Clients will be enrolled into the program as follows:
 - o Clients with existing claims history in MMIS will be enrolled with the PCMP that appears most likely to be the client's historical attending physician.
 - o Clients without existing claims history will be assigned to willing PCMPs based upon client characteristics and PCMP preferences, up to the enrollments limits set by each PCMP.
 - o Clients without existing claims history, who cannot be assigned to a willing PCMP, will be temporarily enrolled with a regional umbrella entity. Formal assignment to a PCMP will only occur when the client first seeks care from a PCMP or upon outreach efforts by the regional entity to obtain a formal PCMP choice.
- Program enrollment is subject to the client's ability to voluntarily disenroll from the program. Clients can veto enrollment for the first 30 days after mailing of the enrollment notice, and before enrollment takes effect. Thereafter, a client may still choose to disenroll for the next 90 days at will. The Department will also honor late disenrollment requests to protect an established physician/client relationship even after 90 days, upon a showing that the client was unaware of their enrollment into the program. In addition, at least once every year, for the 60 days preceding the client's birthday, the client has another opportunity to disenroll from the program, or to change PCMPs.
- Clients currently enrolled in other physical health managed care programs (currently Denver Health, Colorado Access and Rocky Mountain HMO) will not be enrolled into the Accountable Care Collaborative. However, when and if the program expands beyond the pilot phase, any existing "passive enrollment" of clients into a competing managed care plan would cease. The Accountable Care Collaborative will be the primary managed care program in areas simultaneously served by one or more other managed care programs

Provider Perspective

The Medicaid program currently recognizes fifty-six provider types ranging in size and scope from nursing homes and hospitals to durable medical equipment providers and pharmacists. Each provider type plays a highly valued and critical role in treating illness, promoting health or both. In addition, clients interact with a host of non-Medicaid provider organizations that interact with clients ranging from schools, county government services, and independent living centers to transportation services. The availability and interaction among providers and support organizations vary tremendously. Lack of communication and coordination leads to provider frustration, client confusion and also translates into costly duplication, errors, and inefficiency. The Department seeks to promote regional collaboration amongst providers through financial support for information technology, care coordinators, and a regional services contractor. The Department recognizes and values the host of services and providers and seeks to encourage connection and not replacement.

The Accountable Care Collaborative recognizes a coordinating role for a Patient Centered Medical Home. The existing PCPP program will be phased out over time as the Accountable Care Collaborative becomes operational and expands. PCMPs can be sole practitioners, group practices, clinics, or combinations of any or all of types so long as the providers within the combination are related by ownership, control or a common purpose.

In addition, the regional entities will not have the authority to exclude any willing provider from participating in the Accountable Care Collaborative in their regions. The Department reserves to itself, exclusively, the right to set minimum provider participation requirements.

Medical providers currently participating in the Department's Medical Home Program for Children will participate fully as a PCMP.

The Department will have direct contracts with each PCMP, but it is anticipated that the regional entities may also have contractual relationships with the PCMPs to administer monthly PMPMs as well as shared savings programs.

All medical claims will be paid by the Department directly to providers at the then-existing FFS rate schedule. In order to assure complete data sets, all providers will be required to bill the Department using complete service level coding as a condition of participation.

PCMPs would have the essential practice characteristics listed in Appendix E.

After demonstrating the capability to do so, it is possible that the PCMP could also arrange with the regional entity to assume responsibility for all some or all of the various care-coordination activities ordinarily provided by the regional entity.

Non-primary care providers are expected to have a part to play inside the Accountable Care Collaborative as well, but the vision for their involvement is not clear. It is expected that the PCMPs and regional entities will need to address the role of specialists immediately after program inception.

Regional Provider Support Entity Perspective

The Department is proposing contracting separately with several regional entities (four to eight?). Each region would have a governing or advisory body representative of clients and providers.

Any organization, insurer, health care provider, or entity is expected to be eligible to be a regional entity and may submit a proposal in response to the regional entities RFP.

It is anticipated that the pilot phase would focus on 12,000 enrollees (if five regions are determined so that total enrollment is 60,000). The pilot phase enrollees would come from a geographic subarea of the awarded region.

Regional entities would function primarily as a "macro-integrator" in their region. The Department would expect to see strong working relationships between care coordinators, providers, social service agencies and PCMPs, with the opportunity to interact face-to-face on occasion.

Regional entities would also offer support to specialists who join or are associated with the program, by assisting them with difficult cases and/or clients, and by facilitating communications amongst providers.

The regional entities would provide for care coordination, community health, program navigation assistance, and case management services to clients.

Regional entities would be required to have their own robust and scalable software applications to perform case management, care coordination and other functions described herein. There is no intention to standardize or centralize local or regional software systems under the purview of the statewide Data and HIT entity. Regional entities and regional providers may use, create or purchase any software or systems they desire to use to fulfill their needs. The ability to perform analytics internally would be considered critical. However, information exchange among regional entities and the state would be expected and likely follow formats as established by the statewide Data and HIT entity.

Per Member Per Month (PMPM) administrative payments to regional entities are anticipated under this program. The amounts may be variable, depending upon the degree to which local providers assume responsibility to perform regional entity functions for themselves, and potentially by the risk characteristics of the covered population.

Regional entities would be accountable for achieving cost, health, utilization, satisfaction, and access goals. The Department anticipates sharing 40-50% of savings with the regional entities and expects that the savings will be used to incent and reward providers and organizations responsible for achieving outcomes. It is envisioned that infrastructure and investment will be used to also promote proactive, community based services and interventions and to also help foster regional collaboration with other business, social, education, and government entities to promote community health, independence and social integration. The Department anticipates separate initiatives that promote value based payment reform for its contractors and providers. The gain sharing model provides a powerful mechanism for financing towards an outcomes model of health care rather than a pure volume-driven fee-for-service system. The Department is considering setting a percentage of the gain sharing to go to providers and community with the balance going to the regional entity.

Regional entities would be responsible to offer extensive care coordination and other services as described in Appendix F.

Statewide Data and HIT Entity Perspective

The Department is proposing contracting with one statewide Data and HIT entity. This entity would provide and maintain one or several Colorado Regional Health Information Organization (CORHIO) compatible, secure databases containing both client and provider information.

- Client information would include, but not be limited to: Department claims data, CBMS data, pharmacy data, laboratory data, hospital data, imaging data, possibly multi-payer source data, provider EMR data, community provider data (e.g. social services information), regional entity case and disease management data, registry data (e.g. Colorado Immunization Information System), survey responses, PRAMS and BRFSS surveys, and any other kinds of information that would permit the statewide Data and HIT entity to robustly evaluate the health of, and health care delivered to, all enrolled clients. The Department would make available its claims data to the entity, but all other sources would have to be obtained by the entity.
- Provider information would include, but not be limited to, all the information necessary to populate the provider website described herein for the benefit of clients seeking information about participating PCMPs and information monitoring provider compliance with contract standards (e.g. the voluntary client disenrollment rate, which is a measure of client satisfaction).

The statewide Data and HIT entity would develop and encourage the use of clinical registries, and facilitate the use of electronic health information exchange, in order to monitor the clinical outcomes of enrolled clients. In collaboration with other state entities, the regional entity and CORHIO, the statewide Data and HIT entity would encourage providers to adopt Electronic Health Record (EHR) technology to promote health care quality and the exchange of health care information.

The statewide Data and HIT entity would have the expertise to do predictive modeling, analytics, risk stratification and identifying a hierarchy of intervention for enrolled clients. The entity would evaluate all information, do trend analyses, profile, calculate client risk-scores, and respond to provider, regional entity and state inquiries for information and analysis. The regional entity would prepare standard reports, with weekly, monthly, quarterly and yearly deliverables.

The statewide Data and HIT entity would promote a sustainable culture of continuous quality improvement at the PCMP and regional entity level, by providing the data which would drive PDQA processes. This would include collecting clinical measures beyond standard claims data to provide constructive insight as to discrepancies between regional outcomes and performance.

The statewide Data and HIT entity would have the expertise to build and maintain large complex web-based applications, information tools, and registries, with the necessary securities and designs to meet state privacy law and HIPAA. The entity would have the technical expertise to interface with other systems regardless of their technical platforms and to share information bilaterally and efficiently (e.g. Colorado Immunization Information System (CIIS) for tracking all vaccinations).

It is not anticipated that the statewide Data and HIT entity would have any kind of direct client contact, except those that are first initiated by the client (e.g. a client email about poor service) or the occasional client survey. Communication would be rare with the PCMPs (related to contractual compliance concerns), frequent with the regional entity, and constant with the Department.

The statewide Data and HIT entity would coordinate data exchange and assist PCMPs or regional entities seeking to acquire software. The statewide Data and IT entity may develop universal connectivity standards to facilitate data exchange, in cooperation with, or at the request of, the Colorado Regional Health Information Organization (CORHIO).

The statewide Data and HIT entity would implement and maintain a secure email system for the use of clients, PCMPs, providers, regional entities, the State's enrollment broker and the Department to facilitate secure communications between any and all of them.

If federal ARRA funding for HIT is available, the statewide Data and HIT entity would supply average costs for the purchase and initial implementation or upgrade of HIT technology, including support services, training that is for, or is necessary for the adoption and initial operation of, HIT technology to participating physicians, nurse midwives nurse practitioners, and dentists who serve a high volume of Medicaid clients.

DAY ONE The statewide Data and HIT entity would enhance the "eligibility" portal for participating PCMPs so that in addition to verifying Medicaid coverage, the eligibility query would also display the last 120 days of prescriptions filled, emergency room and hospital services, imaging tests and other claims data. Basic client demographic data would be also be added.

In addition, the statewide Data and HIT entity would build or buy HIPAA compliant Web-based services for all participating PCMPs statewide and would implement and support the following functions:

- **DAY ONE** Maintaining a web application database of PCMPs who are accepting new clients, including office hours and ages accepted, to enable the regional entity, the enrollment broker and the Department to assist clients find an available and willing PCMP;
- Maintaining a web application for clients allowing them to view their own claims histories, have secure email communication with their chosen PCMP and also (separately) with the PCMP office staff, display drug interactions and warnings for the medications they have been prescribed, and other customer-useful information;
- Identifying regional variability in care related to preference sensitive conditions, ambulatory care sensitive conditions and supply sensitive care and supplying this information to the regional entities;
- Identifying poor referral practices and outcomes to relay to the regional entities for action;
- Providing to all PCMPs data at the point of care through a Web-based application:
 - o Prescription data
 - o Claims data
 - o Laboratory data and results
 - o Discharge notes from inpatient and ER
 - o Client allergy information
 - o Client cognitive functioning/ability to follow through
 - o Major mental illness diagnoses or any significant behavioral issues
 - o Client Cultural affiliations
- Providing a way for PCMPs to access third party web-based applications easily, such as the Colorado Immunization Information System, so that providers may access all web-based services from a single web application (i.e. “one stop shopping”);
- Identifying families at risk (medical, oral, social, financial, behavioral) and providing this information to the regional entities and/or PCMPs;
- Monitoring regional cost trends and providing this information to the regional entities and/or PCMPs;
- Identifying clients who need appointments and providing that information to the PCMP and/or regional entities;

- Monitoring the adequacy of the local virtual network to meet the expected medical and non-medical (e.g. social, cultural) needs of all enrolled clients and informing the regional entities of capacity issues when discovered;
- Coordinating health information exchange with CORHIO;
- Monitoring PCMP functions to assure that PCMPs are meeting contractual requirements and to monitor practice behaviors. Monitoring includes:
 - o Usage of Web-based provider resources (log-on, data entry, etc.)
 - o Usage of registries (log-on, data entry, etc.)
 - o Provision of prevention services
 - o Minimum enrollment requirements
 - o Whether the PCMP is rendering most of the care (vs. colleague)
 - o Collection and reporting on outcomes and data management
 - o Provider profiling and capture of quality indicators
- Monitoring the regional entities, including conducting PCMP surveys on how satisfied the PCMPs are with the services (timeliness, responsiveness, quality) provided by their regional entity;
- Providing technical/IT Support and training to PCMPs;
- Providing support for integrating state data into local PCMP Electronic Medical Records, and vice versa;
- Providing advice on PCMP office IT purchase decisions;
- Centralized training and support (e.g., on statewide quality initiatives, statewide standards, common data usage, clinical protocols, etc.);
- Informing the Department of data-driven opportunities to improve quality;
- **DAY ONE** The statewide Data and HIT entity would provide the necessary basic accounting expertise and resources to support Department issuance of the correct PMPM payments, as follows:
 - o The statewide Data and HIT entity might act as a third-party claims processor and submit the PMPM bills to the Department on behalf of the PCMPs and regional entities, or it might simply calculate the amounts due, and provide the remittance data to the Department.
 - o Data elements necessary to do these calculations include the identity of participating PCMPs, the clients enrolled with each, the amount of PMPM owed for each client, adjustments to the expected payments due to success or failure on outcome measures, etc.

- o The statewide Data and HIT entity would also provide the clear and user-friendly reconciliation statements to the PCMPs and regional entities explaining the amount of PMPM received by each, for which clients, and which services.

Department Perspective

The Department has primary responsibilities to clients and taxpayers. As the financer and regulator of health care services, the Department seeks to ensure that clients' well-being, health, functioning and self-sufficiency are optimized in the provision of health care services. The Department also has a fiduciary responsibility to taxpayers to ensure that their monies are most productively and appropriately used to meet state and federal statutes and regulations. Furthermore, a high functioning, high performing, efficient social insurance program provides residents and businesses assurance for their own and their communities' potential needs when private markets are not able to provide sufficient coverage, services, or care. The Department recognizes that the current fee-for-system neither optimizes health nor cost. With over 400,000 clients, the state is a large enough risk pool to warrant self-insurance, as is common among nearly all employers above 10,000 employees. Payment of a risk premium of 7-10% would not satisfy our accountability for financial prudence and our intention to self-insure follows the best practice seen in the private sector as reflected by the dominance of ASO/PPO contracts common in the private insurance market for employers over 10,000 covered members. In addition, full capitation can decrease transparency, responsiveness and accountability the state has to clients. Full capitation has not demonstrated long term cost containment and in its current model largely pays providers fee for service. Directing reform exclusively through fee-primary care case management would largely centralize performance management within the state and would lose a regional perspective on care delivery. Regional system development would not be promoted through a purely centralized model of reform.

The Department has thus divided the usual managed care bundle of services in, arguably, quite a novel way. The division, putting PCMP, provider coordination, client support services and outcomes accountability in the regional entity, and data/IT issues in the statewide Data and HIT entity, was made consciously to facilitate trust between the local providers and their regional support entities. The regional entities are facilitators. They help clients and providers. But the statewide Data and HIT entity operates more as an oversight entity: it is the statewide Data and HIT entity that will discover and report gaps, malfeasance, poor performance, broken systems and client dissatisfaction. The Department believes it is important to mitigate the perceived burdens of managed care in order to convince current providers to stay in the new program, and nonparticipating FFS providers to join. In this RFI, data functions appear to be centralized in the statewide Data and HIT entity, even though there is wide appreciation that most, if not all, case management and care tracking functions are built upon robust and complex HIT already — and these functions are assigned to the *regional* entities. The Department fully expects regional entities to bring with them their own software and information systems. These will not be supplanted or superseded by other software from the statewide Data and HIT entity, though it may be necessary for the regional entities and the statewide Data and HIT entity to cooperate on information exchange between their systems, and both entities need to assure that any PCMP used web-based applications are consistent with the Department's "one stop shopping" vision.

The Department will retain control over all symbols, experiences and associations connected to the Accountable Care Collaborative (i.e. "branding") to assure a state wide Colorado brand rather than five separate regional brands. While the regional entities may have some distinguishing characteristics and different names, the entire program is state-sponsored and it will appear to be an integrated single product to the public.

The Department will retain the policy authority to determine which measures, standards and metrics are to be used throughout the Accountable Care Collaborative. This includes all quality assurance standards, quality improvement standards, and practice standards. The Department will work collaboratively with all stakeholders to choose and develop these standards and will likely emulate the successful way in which the measures, standards and metrics were collaboratively developed in Medical Home Program for Children. Regional entities would be expected to participate in the collaborative process, as would the statewide Data and HIT entity, however, the Department will retain the authority to establish these critical standards for the entire program.

A schematic that shows the interrelationship of the statewide Data and HIT entity, the regional entities and the local PCMPs is attached to this RFI as Appendix D.

15. Program Inquiries

The Department seeks to reform the Colorado Medicaid health care delivery system into a primary-care centered, outcomes-driven model that is focused on the “whole person” needs of the Medicaid clients.

15.1. Basic Questions

In order to efficiently compile all the feedback expected to this RFI, please answer the following questions to help us sort and group respondents and their answers together.

1. Please choose the best description of your or your organization:
 - a. Medical provider
 - b. Provider advocate (e.g. medical society)
 - c. Client
 - d. Client advocate
 - e. Potential regional entity
 - f. Potential statewide Data and HIT entity
 - g. Potential regional and statewide Data and HIT entity
 - h. Foundation
 - i. Another public or private program
 - j. Legislator
 - k. Other (please describe)
2. What is your overall impression of the Accountable Care Collaborative program?
 - a. Very favorable
 - b. Favorable
 - c. Neutral
 - d. Unfavorable
 - e. Very unfavorable
3. What is the likelihood that you will seek to participate in the program?
 - a. Very likely
 - b. Likely

- c. Reserved (waiting to see the RFP)
- d. Unlikely without significant changes
- e. Will not seek to participate

15.2. Questions for Potential Regional Entities

4. Would you be interested in forming or participating in the formation of a regional entity to provide the services described herein? Please provide your organizational name. If you have a parent company or organization, please provide that information as well. What is your current relationship with the Medicaid program?
5. Under what legal structure would the regional entity operate? Corporation? Partnership? Other forms? Non-profit or not-for-profit? What are the advantages and disadvantages of the various legal structures? Are there antitrust complications or concerns? If so, how should they be mitigated?
6. Should the Department require that regional entities have or seek accreditation by AIRS (www.airs.org) as a contract requirement?

The Department is aware that the regional entity has the ability to exercise a great deal of influence on the existing local balances between competing networks, businesses and alliances operating in the regions. If any one local business is able to exercise control over the regional entity, it might come at the detriment to its local competitors. Likewise, the possibility that an out-of-state entity might control the regional entity creates different kinds of competitive concerns.

7. The Department is leaning toward requiring an advisory council for each regional entity and guaranteeing a place on it for clients, local public health departments, a mental health advocacy group, the Department of Public Health and Environment (DPHE) and the Department of Human Services (DHS). Do you agree that there should be an advisory council? Should these entities have guaranteed participation? Should other entities be added to the required list?
8. What kinds of activities or projects should be considered for required reinvestment by regional entities?

Central to this initiative is accountability for performance. In return for the accountability, the Department intends to allow flexibility in regional design and reward accomplishment with shared savings. The Department seeks to encourage novel delivery systems that promote achievement of performance (for example, supporting lay health educators or rewarding community providers for reducing emergency room visits).

The Department is considering a set of accountability metrics for health outcomes, risk factor reduction, timely access to care, client satisfaction, reductions in avoidable and preventable health care resource utilization, and per capita cost targets.

The Department serves many eligibility types and recognizes that the goals for differing eligibility types may differ.

The Department also intends to use some practice-level and community level measures as basis for later year incentives. Recognizing that existing national quality measurement systems do not adequately target or respond to the unique healthcare needs of children, it is anticipated there will need to be measures for adults and other measures for children. The Department is evaluating the feasibility of offering the PCMPs a base monthly PMPM. In addition to this base rate, the PCMPs might receive more PMPM for additional services, meeting outcomes goals, or as an incentive. (For example, if the PCMP has at least 5 percent of their practice (200 people) in Medicaid, the PMPM would be slightly larger, if the PCMP used the Web based application for look-up, there would be more PMPM, and it would be even larger if the PCMP agreed to enter clinical data in the statewide Web application.)

9. What is the strategy that should be used to transition between yearly measures and how far in advance should these measures be identified?
10. What would be suggested percent weightings for accountability for the following categories: 1. timely access to care, 2. health outcomes and risk factor management, 3. client satisfaction, 4. appropriate health care resource and cost management?
11. For healthcare resource utilization, The Department is considering a target on emergency room utilization, 30 day readmission rates, ambulatory sensitive condition hospitalizations reduction, preference sensitive care variation reduction; please add other areas and/or comment on the proposed set.
12. The Department is considering to using three /utilization measures to determine a portion of the performance incentives: (1) Emergency Room (ER) utilization, (2) ambulatory care sensitive inpatient admissions, and (3) repeat hospitalizations. These are purposefully not practice/provider level measures in order encourage accountability for the most costly and uncontrolled system costs. What kind of data and support would you be able to offer the providers to help them managed these extra-clinical costs and expenses? Are there other utilization metrics we should consider?
13. The Department would like CPI adjusted, per eligibility category, total PMPM to increase no more than 5% per year. Is that achievable?
14. The Performance Measure Advisory Group (PMAG) has developed a list of quality metrics for children, would responders propose that these be a basis for health performance assessment for children?
15. The Department intends to have regional entities assess client health and functioning through a validated tool like an *SF-12* for adults and *SF-8* for children. Are there other tools to consider?
16. The Department recognizes that it will have to have health goals appropriate for the age and need of client populations. What specific health and healthy behavior goals are recommended by age or eligibility?
17. Please comment on the advisability of requiring HEDIS compliance?
18. The Department has attached selected *Healthy People 2010* metrics in Appendix G. Which ones would responders prefer or would like to add?

19. Wisconsin's metrics are attached in Appendix H. Please comment on their completeness.
20. The Department anticipates requiring a CAHPS survey as its metric for client satisfaction. Please comment.
21. The Department is considering access measures such as: (1) time from initial request until appointment, (2) time from appointment to the next follow-up visit, (3) the percentage of PCMPs with open panels, and (4) the time from identification of initial need until a specialty referral appointment is made. Please propose other access metrics and comment on the ones proposed.
22. If the costs of programming a variable PMPM administrative fee are too great for the Department to incur, would the regional entities be willing to assume the PMPM payment function to the PCMPs, using the variable rates, and be paid by a single remittance from the Department?
23. The Department believes that dual eligible clients may need additional and/or different quality incentives. Long-term care services are not directly within the scope of the accountable care collaborative and cannot be directly managed by either the PCMPs or regional entities. Are Skilled Nursing Facility bed day reduction and transition of care between settings appropriate measures given the inability to directly control these costs? What health and healthcare goals should be adopted for this elderly population? Is there an effective way to measure and incentivize management of waiver/Home Health expenses? What health promotion goals should be adopted for this population? Would you be willing to partner with the Department and initiate conversations with CMS/Medicare on sharing Medicare savings achieved by the Accountable Care Collaborative?
24. What needs to be changed or remedied with Medicaid processes or procedures before the Accountable Care Collaborative is instituted?
25. In what way(s) will the creation of the Accountable Care Collaborative create duplication of efforts and how can duplication of efforts and services be avoided?
26. How can the Department ensure that all appropriate current effective community-based organizations are appropriately included?

Standardization facilitates the alignment of efforts with other payers using the same standardized measures. Permitting regional standards would make it difficult to compare the outcomes of one region with another and it would enable local special interests to unduly influence practices that have no compelling reason to be different between regions. Disparate regional measure sets also reduce the statistical power of analysis; decrease the opportunity for meta-analysis and the value of utilizing data in promoting quality improvement statewide. Nonetheless, the Department does not want to impose statewide standards on local providers. Instead, it is proposed that the regional entities, acting on behalf of their local provider participants, would work together to create the uniform standard through multi-payer meetings.

27. Should the Department promote protocols or best practices? Or instead should the Department's performance metrics drive regional solutions for their accomplishment?

28. Should the Department encourage or require participation in multi-payer meetings at the state level to review and adopt evidence-based treatment protocols and best practices? Please identify any best practices that should be coordinated across multiple payers.
29. Do you believe the regional entities should support development of standardized evidence-based state-wide treatment standards and protocols? How would you involve your local providers in the process to assure buy-in and ownership of the results? Should the Department associate with or use a particular group or organization such as the Colorado Clinical Guidelines Collaborative (CCGC) when developing uniform standards? Which ones? Or do you believe the regional entities should prioritize themselves which protocols to implement and promote?
30. Disabled clients are concerned because standard approaches to care either don't work or are too limiting. How should these concerns be addressed?
31. Practice coaching is currently being done throughout the state in the Department's Medical Home Initiative/Colorado Children's Healthcare Access Program (CCHAP) and through the Colorado Clinical Guidelines Collaborative (CCGC) Improving Performance in Practice Initiative (IPIP). In addition to a practice gap-analysis (identify the practice's strengths and weaknesses, service gaps, and communication skills), practice coaching also results in the development of a plan to improve the practice with an eye to improving efficiency and the bottom line. What kinds of tried and tested practice coaching methods do you provide? Should practice coaching be required or optional? Please identify these programs and describe the elements of these alternative systems.
32. The Department is considering promoting group visits for clients to promote peer-to-peer learning. What do stakeholders believe is the importance and value of group visits?
33. Are there existing coordination or integration efforts already in place or in development that might be impacted by the Accountable Care Collaborative? What are these efforts? What measures should the Department take to include or account for these efforts in the Accountable Care Collaborative program design or contracting?
34. Physical and behavioral health care coordination is a key area of program focus. There are independent contractual duties requiring the behavioral health organizations (BHOs) to coordinate and cooperate with primary care medical providers. What expectations should the Department require of the BHOs to maximize effectiveness of this program, but minimize duplication between the two programs?
35. Are there any systemic issues that might hinder the necessary cooperation between the physical health providers and the BHOs (e.g. use of Behavioral Health Codes and billing for same day appointments that involve a care management or behavioral health components)? What can be done to ameliorate these issues?
36. The medical home legislation for children requires dentists and some behavioral health practitioners to be able to be the focal point of care, or medical home, for children. Adult clients do not receive dental benefits in Medicaid, but should the same group of behavioral health practitioners be able to be the medical home for adult clients? How can the Department accommodate this requirement when behavioral health practitioners are all reimbursed through a separate capitated managed care plan?

37. How would you propose coordinating with the Health Care Program for Children with Special Needs, the Colorado Home Intervention Program and the Early Intervention, Early and Periodic Screening, Diagnosis and Treatment Programs? Should the targeted case management (TCM) for these programs be run at the regional level by regional entities or should these existing programs continue to provide clients with TCM services? If these programs continue to provide TCM services, how should the regional entity care coordinators (navigators) collaborate?
38. Are there other medical or non-medical areas in which regional entities should have expertise and should coordinate the delivery of services other than the ones described herein?
39. The Department has been intrigued by results of regional care transition efforts focusing on readmission reduction and the evidence supporting dramatic reductions in readmissions. Should care transitions between care settings be a required or suggested element of the model?
40. The Department would like to maximize and expedite the achievement of program goals from day one, should the Department require regional entities to possess proven results for chronically ill and disabled clients? Should the Department require regional entities to adhere to the standards adopted by, or have actual accreditation from, NCQA?
41. What capabilities, accreditations or achievements should the PCMP have to demonstrate before the regional entity delegates care-coordination, and its associated funding stream, to the PCMP? Regional entities will be responsible for assuring and monitoring that the PCMP is fulfilling the sub delegation responsibilities. What concerns would you have on assuming or enforcing these expectations?
42. What kind of case management is realistically achievable in this program? How should “serious conditions” be defined? What kinds of case management services, for which clients, would best serve the program model?
43. Many of the clients enrolled in the Accountable Care Collaborative will have chronic conditions and multiple morbidities with significantly higher rate of emergency room, in-patient and pharmacy use than the general Medicaid population. The current design envisions that this population would be served locally by the regional entities. Is it better to centralize responsibility for these high-cost high-needs clients in the statewide Data and HIT entity? Why?
44. The Department believes that PCMPs might be slow to adopt Web-based information services until they reach critical mass and offer compelling value and ease of use. The current Department vision is to offer a single web application that shows a 360 degree view of their client’s medical and social needs.
 - a. If the web-based information service provided ready-made cultural dossiers on acceptable behaviors, courtesies, customs and expectations which are unique to families of specific cultures and ethnic groups, or to clients with disabilities, would this function attract PCMP use?
 - b. If the regional entity or others entered non-medical client activities (such as social service activities, SEP activities, social worker activities, educational activities,

etc.) would this information offer compelling enough values that the PCMP is likely to access it and use it?

- c. If the web-based information service offered secure HIPAA compliance email communication with the client, other PCMPs, specialists, the Department, the regional entity, the enrollment brokers, SEPs and other entities, would this function attract PCMP use?
 - d. What other functionality, or critical data collected, is necessary to achieve minimum critical mass, compelling value and ease of use that will encourage PCMP use?
 - e. The Department's vision for a **DAY ONE** deliverable is an enhanced version of the eligibility portal. In addition to receiving verification of eligibility, the PCMP would also receive information on the client's prescriptions and other utilization information derived from claims data. The PCMP's staff could print this information and put it into the chart. How should future enhancements be determined? Should there be pilot programs? How should PCMP buy-in on design and usage be obtained? How should PCMP usage be monitored to know whether or not anyone is even using the new web based application?
45. What kinds of information should the regional entities gather and provide to the statewide Data and HIT entity for web publication?
46. Should interested organizations be allowed or required to bring their own networks of providers as a requirement of the RFP for the regional entities (recognizing that the state will pay all claims and that each provider must at least have a Medicaid ID number)? The Department prefers to know the identities of the PCMPs to evaluate regional entity proposals. But given the shortages of health professionals in some areas to be served by the collaborative, should the regional entities be allowed to start in their areas without having any PCMPs committed in advance?
47. Other state models have required its regional entities to have a part-time paid Medical Director, a Clinical Coordinator, Care Managers and a Pharmacist on staff. The Department is interested considering this model. Would you be able to do it? How much would this cost? Do you think that the Medical Director should be elected by local peers? Should the offerors for the regional entities be required to identify, by name and experience, each person in the various positions identified in the RFP? (Medical Directors would likely be brought together to give significant strategic advice to the Department.) Is there other required staff that should be added to the list?
48. The Department is leaning toward having several regional entities so that there are both a critical number of clients to sustain costs, and also geographic regions that are small enough that there is true local accountability. The Department anticipates a pool of 100,000 clients if five regions are determined. What is the minimum number of total eligible clients? (Several different regional mapping arrangements have been attached to this RFI in Appendix B. There may be others. What regional boundaries would you be willing to submit a proposal for? Do you have other maps to recommend, perhaps based on pattern of care analysis, given the Department's requirement that there be no overlap in regional service areas to accommodate the necessary enrollment functions? How should the Department account for tertiary patterns of care (access to academic centers and experts) when defining regions?

49. For the regional entities, how would you prove that you can meet the following essential requirements:
- a. Having existing relationships with Colorado primary care practices, clinics, IPAs, commercial networks or FQHC providers; or being formed by them? Having existing relationships with other local stakeholders, for example client advocacy groups? What groups or entities should have a place on the governing board of the regional entity?
 - b. Being able to provide some traditional case management services for high needs cases, and how those services would be provided to support rather than interfere with PCMP decision-making and autonomy?
 - c. Being able to provide culturally and linguistically appropriate services (CLAS) to all clients?
 - d. Knowing the specific communication and practice needs that are relevant to persons with disabilities (e.g. a posted process for how a client requests a reasonable modification of a PCMP policy, practice or procedure; having a calm, quiet and orderly waiting room; not having a button phone menu, etc.)?
 - e. Having experience with special health care needs clients?
 - f. Having existing relationships with Colorado stakeholders, e.g. client advocacy groups, physician IPAs, and others?
 - g. Having the ability to collect, aggregate and report data for quality improvement and population health?
50. Should a regional entity be allowed to also become the statewide Data and HIT entity as well? If it were allowed, what measures should be put in place, if any, to assure efficient and amicable relations with other regional entities? Should a regional entity be allowed to propose for multiple regions?
51. The Department currently has two contractors performing utilization reviews, prior authorizations and retrospective reviews. Should the regional entities be given some of these functions for enrolled clients? Which ones? Why? Should the program include some form of concurrent inpatient review function? What other medical management activities would you suggest be employed?
52. Will this model generate more participation interest on part of PCMPs? If not, what incentives or design would generate the most participation from PCMPs?
53. If the PCMPs desire extended hours coverage from the regional entities too in order to fully support the PCMP extended hours, would you be willing to participate? If not, would you participate if the regional entities would provide extended hours coverage for each other (e.g. each entity has extended coverage on a different day, and the “covering” entity provides support services state-wide to all regions)?
54. Recognizing that existing national quality measurement systems do not adequately target or respond to the unique healthcare needs of children, it is anticipated there will need to be measures for adults and other measures for children. Which measures

55. The Department believes that dual eligible clients may need additional and/or different quality measures. Long-term care services are not directly within the scope of the accountable care collaborate and cannot be directly managed by either the PCMPs or regional entities. Are Skilled Nursing Facility bed day reduction and transition of care between settings appropriate measures given the inability to directly control these costs? What about quality measures around bowel impaction prevention, wound care, or medication errors? What goals should be adopted for this elderly population? Is there an effective way to measure and incentivize management of waiver/Home Health expenses? What health promotion goals should be adopted for this elderly population? Would you be willing to partner with the Department and initiate conversations with CMS/Medicare on sharing Medicare savings achieved by the Accountable Care Collaborative?
56. What goals should be adopted for individuals with disabilities?

The Department provides health care for approximately 60,000 adults aged 18-64 that are eligible for social security and Medicaid benefits due to chronic physical and/or behavioral health challenges. These clients are cared for in a number of settings, have multiple morbidities and have a significantly higher rate of emergency room, in-patient and pharmacy use than the general Medicaid population. The Department seeks to improve the health, functioning and self-sufficiency for these clients in the Accountable Care Collaborative.

57. The SSI population has a high rate of dual physical and behavioral health diagnoses. Are there systematic tried and true ways to ensure that coordination between physical and behavioral health providers happens? How should the regional entity support coordination of care between physical and behavioral health providers for the SSI population?
58. Share your experience working with client advocates. What activities or characteristics should the Department evaluate to identify vendors who have demonstrated a successful collaboration with client advocates?
59. Share your experience working with caregivers. What activities or characteristics should the Department evaluate to identify vendors who have demonstrated a successful collaboration with caregivers?
60. For regional entities, what practices should the Department be looking for in regard to reducing ER visits? Which practices should the Department expect the PCMP to perform and which should the regional entity perform, in regard to monitoring and reducing ER utilization?
61. What are best practices for reducing in-patient admissions for ambulatory care sensitive conditions such as asthma exacerbation, diabetes or depression? Which practices should the Department expect the PCMP to perform and which should the regional entity perform, in regard to monitoring and reducing in-patient admissions for ambulatory care sensitive conditions?

62. How should the regional entity support the PCPM in avoiding hospital readmissions within 90 days? Should the regional entity be responsible for follow-up care after discharge? What are the key elements the regional entity should provide as part of hospital discharge follow up? Which practices should the Department expect the PCMP to perform and which should the regional entity perform, in regard to avoiding hospital readmissions within 90 days?
63. Should high needs clients be identified? How would you define a high needs client?
64. How should the regional entity address the needs of clients with complex medical needs living at home and on a waiting list?
65. How should the regional entity coordinate its duties with the comprehensive case management provided in the DD Community System?
66. Describe how the regional entity should interact with community stakeholders such as clients/families with special needs, client advocacy groups, community services organizations, etc.
67. Should the regional entity support a formal client appeals and/or grievance process? (42 CFR 438.402 does not require a formal grievance process for PCCM contracts, nor does it require a separate appeals process.)
68. Should offerors for regional entities be allowed to propose on more than one area, and if so, how many? What should the Department do if there are no proposals submitted for a regional service area?
69. How long it would it take to get this model off the ground after the start of the contract?
70. How many clients can be enrolled maximum each month for the first six months of the program?
71. What would you do if you had technical and financial support, or if money were no object?
72. Is there a different PCCM program design that could produce similar or greater cost savings for the Medicaid population that is superior to the one described herein? Over how long a period of time?
73. Should client self management support (behavior modification and self-efficacy for clients through education materials, tools, counseling, group visits, etc.) be a function performed by the regional entity, the PCMP or both?
74. What do you know about serving Medicaid clients that we don't know or haven't tried? What do you do for this population now?
75. For the pilot phase (focusing on demonstrating results for a subpopulation of 12,000 per region), should clients be selected proportionally thus promoting generalizability or disproportionately thus promoting early success. If disproportionately, how so? What evidence do you have to support earlier or higher success with a disproportionate approach?

76. The Department believes it will be essential to have a third party evaluate the efficacy of the program.
- a. Do you agree that a third party should conduct the study rather than the Department, a regional entity or the statewide Data and HIT entity?
 - b. Should the regional entities be made responsible to find and fund the evaluation if another source (such as grant funding) cannot be found?
 - c. If the Department contracts for the evaluation, would the regional entities be willing to provide the funding?
77. Do you have general reactions to the model design not otherwise expressed in any of the other responses?

Specialists, hospitals, pharmacies, home health providers, nursing facilities and other providers will play a key role in the development and delivery of services and common care programs for clients. The Department envisions these other providers to be active participants in the Accountable Care Collaborative. The Department recognizes that PCMPs cannot be responsible for coordinating all aspects of client care. Therefore, in order to be successful, all medical providers must have a stake in shared goals and participate in the sharing of savings.

78. How will you facilitate and support members of the provider community coming together to form partnerships and work with regional entities to create a collaborative delivery system.
79. What type of technical assistance would be needed to support these other community providers in forming partnerships and negotiating active roles within the regional entity?
80. As a regional entity, how do you view your role in this relationship?
81. As a regional entity, have you taken any steps to work with other medical providers toward partnering with you?
82. How can regional entities identify providers in local communities that may be interested in participating in the Accountable Care Collaborative, since the Department expects regional entities to collaborate with the rest of the provider community?
83. How can the regional entities establish relationships with the rest of their provider community? Should the Department require formal relationships in the form of written contracts?
84. How can community providers be aligned with regional entities to achieve program objectives and share in financial incentives?

15.3. Questions for Clients/Client Advocates

The Department would like a coordinated system of client care including medical, oral, behavioral and social care, using a whole-person approach.

85. Would you be interested in participating in the Accountable Care Collaborative as described herein? Please identify yourself or your organization. What is your current relationship with the Medicaid program?
86. What expertise involving social services and other community or governmental programs should the Department require the regional entities to have/obtain?
87. The Department intends to use an improved automated enrollment process, described fully at the beginning of this proposal. Would you support passive enrollment done in this improved manner. If not, how should enrollment occur?
88. What do you need us to require of participating PCMPs? (e.g. special training classes)
89. What experience do you have with vendors that have successfully supported disabled populations?
90. What types of social services should the regional entities have knowledge of? Please list in as much detail as possible.
91. The Department is considering having the regional entities maintain childcare resources to enable clients with children to attend medical and non-medical appointments. Would this be a service you would be interested in using?
92. What are the key program requirements for you?
93. What kind of special tests or assessments (beyond the established EPSDT developmental tests), such as special developmental, functional or cognitive, would you like the regional entities to be able to perform?
94. Please propose health, healthcare, satisfaction, and access performance metrics for the Department's consideration.

The Department is interested in building a provider "home page" for each PCMP in the network. It would be thoroughly searchable and have enhanced provider data such as:

- Licensure and education
- Specialty
- Location(s)
- Practice emphasis
- Awards and recognitions
- Endorsements by special interest groups or entities
- Affiliations
- Other private insurance accepted
- Credit cards accepted
- Hospitals with which the PCMP has privileges
- Cultural background, languages spoken, etc.
- Special physical accommodations available at the location

- The availability of free parking and its proximity to the office
- Whether the PCMP has experience with clients receiving long-term care
- Whether the PCMP has experience treating clients with disabilities
- Whether the PCMP uses secure email to communicate with clients
- Whether the PCMP is accepting new patients
- Whether walk-in appointments are available and when
- Whether the PCMP participates in the opentable.org Web-scheduling application
- Whether the PCMP has a live response to calls, or an automated call-in system (i.e. “press one to make an appointment, press two to. . .”)
- Links to the PCMP’s other websites (e.g. commercial sites)
- Direction on how to find the provider by bus route and Google maps
- A picture of the location to make it easier to find once the client arrives
- Optional pictures of the physicians and staff
- A place for the PCMPs to talk about themselves and their practices
- The identities and contact information of “covering” PCMPs and after-hours locations where treatment can be obtained

Included on the page would be reportable statistics gathered by the statewide Data and HIT entity about the PCMP such as:

- The PCMPs’ quality scores and ranking with other PCMPs
- The PCMP’s well care statistics for meeting the state’s periodicity schedule
- The average time clients wait in the reception area before seeing the PCMP

The Department is also interested allowing clients to publicly rate the physical location, the PCMP and staff akin to how Amazon allows purchasers to rate products, with star ratings and narratives. The client would be able to give direct secure email feedback to the PCMP and/or to the Department about their experiences and treatment by PCMP and staff. Clients would also be asked to report on the wait time they experienced while in the PCMP’s reception area.

95. Do you have regular and reliable access to the internet?
96. Would you be interested in accessing and using portions of a PCMP Web page?
97. Is there other information about the PCMP that you would like to appear on the Web page?
98. Should other provider types also have similar pages? Hospitals? Home health agencies? Pharmacists? Etc.
99. What other items or information would you like the Web page to contain?
100. Would you use a search function that allowed you to select multiple criteria and have all PCMP matches returned at once?
101. If the function was available, would you like to schedule PCMP appointments through the Web instead of calling the PCMP office? How about for other providers?
102. Would you like to see a list of all the available appointment slots that your PCMP has for the next two months? Which other provider types?
103. Would you like emergency room provider to be able to schedule follow-up appointments with your PCMP for you, before you leave the emergency room?

104. Would you like the ability to rate your PCMP and other others the way customers on Amazon.com can rate products? Would it be useful to you to read other client comments on their experiences? Would you use this information when choosing a doctor?

The Department is considering creating a secure client Web application to allow clients to view their own claims histories, have secure email communication with their chosen PCMP and also (separately) with the PCMP office staff, display drug interactions and warnings for the medications they have been prescribed, and other customer-useful information.

105. Would you be interested in accessing and using a secure, private personal Web page?
106. Would you like to be able to look up your prescriptions on-line? Would you find the drug interaction information to be useful?
107. The Department sees additional convenience if the prescription list could be printed. The client could then carry the list in purse or wallet and should the client need to see emergency services, the list could be presented to the emergency room doctor. This could prevent accidental medication interactions when the client is unable to recall all of the prescriptions. If you could print your prescription list, would you carry it with you?
108. Would you be interested in having secure email communications with your PCMP to discuss medical issues? The Department sees some advantage to both parties by having email available. Clients can get answers to medical questions without having to make an office appointment, and physicians can answer these questions in writing when they have time. The client is relieved of the burden to stay near, and off, the telephone awaiting a phone call, and the PCMP is relieved of the burden of making a rush phone call between appointments.
109. Some advocates have expressed a desire that some medical care not be coordinated on purpose. For example, that psychiatric information not be made available to medical doctors, or even information that psychiatric services are being sought. If the Web-based application required specific consent before information is shared between service providers, would this alleviate privacy concerns? Would you agree that it is important to have the medical PCMP aware of psychiatric medication prescriptions to avoid accidental drug interactions with any physical medication prescriptions?
110. What else would you like the client Web page to contain?
111. In traditional managed care, several very-important client concerns are often unmonitored, or are monitored only sporadically with difficulty and expense through secret shopper programs. CAHPS can monitor general client satisfaction, but it does not provide the kind of micro-detail to address concerns like reception area wait times, delays in obtaining an appointment, busy phone lines, long "on hold" times, provider failure to know or implement CLAS standards, dirty reception areas, etc. The best monitoring comes from the clients themselves, but it is not easy to complain, or to know how to complain. Would you be willing to respond to frequent email surveys asking about these concerns? Would you be willing to use a Web based application designed to make complaints? Would these mechanisms be adequate to improve these kinds of clients concerns? Are there other mechanisms that should be used that are easier to implement than the traditional secret surveys?

112. Do you have other feedback that you would like to share about the Accountable Care Collaborative?

15.4. Questions for Statewide Data and HIT Entities

113. Would you be interested in forming or participating in the formation of a statewide Data and IT entity as described herein? Please provide your organizational name, headquarters location, year of incorporation or creation. If you have a parent company or organization, please provide that information as well. What is your current relationship with the Medicaid program?
114. What is the estimated cost of providing the above described services for one year?
115. Are there activities described herein that you believe should not be the responsibility of this Data and HIT organization?
116. What data activities outlined above, if any, do you consider essential to have prior to establishment of the regional entities?
117. Which IT and data functions do you think are most important to be implement first?
118. Some services currently associated with the regional entities could be provided by the statewide Data and HIT entity instead. The Department is not inclined to reallocate some of the functions assigned to the regional entity if for no other reason that to complicate the PCMP yet again with the question, "I have a problem, which organization was supposed to help me with it, the regional or the statewide Data and HIT one?" Under the current model, contacting the regional entity for all client-related issues is *always* the right answer. Nonetheless, if there is a strong consensus among all stakeholders to the contrary, the Department will reconsider the allocation of functions between regional and state entities. Which, if any, of the following functions do you feel would be better assigned to the Data and HIT entity rather than to the regional entity, and why?
- a. Case management
 - b. Customer and provider service (call centers)
 - c. Provider network development and provider contracting
 - d. Practice coaching/redesign
 - e. Nurse advice line
 - f. Multiple user case tracking software
 - g. Utilization management
 - h. Business intelligence/data analytics
 - i. Predictive modeling
 - j. Translation services

k. Other?

The Department believes it is useful to have a standard, state-wide web-based care plan and decision support tool that would be available to all providers, social services organizations, care managers, the Department, the enrollment broker and all other entities that touch the client (subject to appropriate HIPAA protections and user level permissions). However, it is expected that some or all of the regional entities might already have specialty software that provides some or all of this functionality.

119. Is a state-wide standardized care plan and decision support application necessary? Or is non-standardization preferable, to allow regional entities to buy and use their own preferred systems? If non-standardization is preferred, how can the information contained in one regional system be made available to another region if the client should move locations and change regional areas?
120. Would you prefer to build the statewide Web-based applications from scratch, use free Medicaid funded applications from other states or use an existing commercial or proprietary product?
121. What are the minimum technical requirements that the Department should require of the statewide Web-based software application platform?
122. What is the minimum technical expertise that the Department should require of the statewide Data and HIT entity and their employees?
123. Is it feasible and affordable to build a Web-based appointment availability function like the "opentable.com" restaurant service so that available PCMP and specialist appointments can be made via the Web. (See the functional description under the next section.)
124. What other potential activities/roles could the statewide Data and HIT entity provide to support regional entities and PCMP practices?
125. How long it would it take to this model off the ground after the start of the contract? Can all **DAY ONE** function be up and ready by the first enrollments in July, 2010? What is the timeframe to have all other functions operational?

15.5. Questions for Primary Care Providers

126. Please provide your name, location, area of practice and specialty. What is your current relationship with the Medicaid program? Do you currently participate in managed care or under the existing PCP Program?
127. Would you be interested in forming or participating as a PCPM as described herein? If not, how would you prefer to establish medical homes for clients dealing with chronic poverty and health issues? What specific accommodations would you be willing to make to assist in achieving positive health outcomes (i.e. flexible scheduling, oral communication)?
128. The existing PCP Program requires PCPs to assume approval functions relative to referrals for specialty care and other kinds of acute care benefits (i.e. the specialist and other medical provider must add referral information to their billings to receive payment).

Should this approval function be retained in the Accountable Care Collaborative? If not, what substitute measures will prevent clients from seeking care out of region, or from doing self-referrals to specialists or other PCMPs?

129. How can regional entities identify providers in local communities that may be interested in participating as a PCMP or specialist in the program, if the Department requires a preexisting network as part of the solicitation process?
130. What kinds of providers should qualify as PCMPs?
131. Do you have operations state wide or that are likely to cross over into several regional areas? Does the Department's desire for regional responsibility and accountability interfere with your operations if your local clinics operate under different regional entities with different expectations and responsibilities? How can the Department mitigate the fragmentation while still honoring the goal of giving the local regional participants local accountability?
132. What do you think about having regional and centralized support functions?
133. Should the regional entities also offer extended hours and weekend coverage?
134. Would you be willing to work collaboratively with other PCMPs in your region to define the requirements for 24/7 after-hours phone services for your kind of practice (e.g. pediatricians might provide experienced clinical personnel using advice based on accepted national pediatric phone-triage protocols with same-day follow-up to the child's Medical Home while adult-centered practices would use different protocols)?
135. The Department recognizes over 50 types of providers; much of the care delivered to clients will not be delivered by PCMPs but by pharmacists, home health nurses, county agencies, etc. Would a web-based, common care plan facilitate communication and coordination of care? How do better support multi-disciplinary and team approaches to care?
136. The Department envisions the regional entities providing case management services for catastrophic cases. The "catastrophic" limitation is partially budget driven; traditional case management services are expensive, and partially in recognition that PCMPs are expected to be the case managers for all their clients. A secondary concern is the perceived interference that traditional case management services may have with the PCMPs own case management prerogatives.
 - a. At what point, and under what circumstances, would you like to have professional nurse case management staff available at the regional level to take over, or supplement, your own case management?
 - b. What kind of case management services would you like to have available at the regional level? What kinds of case management do you not want available at the regional level?
 - c. What kinds of clients, illnesses or conditions, would like to have regional case management support for, and which ones would you not?

- d. Where should the Department draw the line between PCMP case management of your own clients and the case management by the regional entities?
 - e. Should case management be proactive versus reactive (i.e. using advanced analytics in combination with early health risk assessments to initiate case management for potential high-cost high-need clients without PCMP action)?
137. The Department has constructed the program based in part on an assumption that local PCMPs want to have a meaningful voice in the way the regional entities operate, how they expend their resources, and possible who they are. However, early feedback from commercial entities interested in the regional contracts, and from managed care entities, is that there should not be so many regions and that the entities doing the regional functions should be fewer and state-wide. Is the Department's assumption about the desire for local control incorrect? Do you want to have the benefits of local influence and control (with the associated burdens of having to become active and engaged) associated with the several smaller regional entities, or would you prefer the simplicity of just one or two larger organizations providing all functions state-wide? How important is the program design of local autonomous regions to PCMP participation? Would you still participate without the ability to exert influence at the local level?
138. If local control is not a concern, should the Department obtain the functions associated with the regional entities from two state-wide entities only? Would the market competition between two larger entities assure services equal to or better than the ones you would obtain by exercising local control over smaller regional entities?
139. Is the five percent of Medicaid clients practice goal for small practices too burdensome? If so, what would it take to entice you to expand your Medicaid participation to this level? How should the minimal client level be measured? Clients with active care in any 12 month period? Clients who have designated the PCMP as the attending PCMP even if no treatment is sought? What is the equivalent percentage for large group practices or health plans that choose to operate as group PCMPs (e.g. Kaiser or Denver Health)?
140. Would you be willing to participate and agree to the minimal client census requirements for gain-share opportunity?

The Department would invite specialists to become PCMPs in the Accountable Care Collaborative, especially those who are the primary physicians for clients with chronic specialty conditions. However, there has been some expressed unwillingness for the specialist to assume responsibilities or treating the client's wellness needs or other needs outside the chronic condition. There is the sense that specialists would prefer to deal only within their specialty and that a primary care physician should deal with all the rest.

141. Should specialists participate as PCMPs in the Accountable Care Collaborative? How? Should specialists have to assume the same whole-person responsibilities that primary care providers assume, or something else? How can deviations be compatible with the Medical Home standards in Appendix C? What changes in reimbursement and/or administrative support would create improved access to necessary specialty care? If you are a specialist, what would be necessary to incentivize your participation in the program?

142. For clients who do not have a PCMP or do not select one, would participating specialists prefer to receive clients by lottery (to even out the flow and the burden) by queue maintained by the regional entity?
143. What steps are you willing to undertake to assume responsibility for the some of the above population health metrics within the confines of the design and resources as described herein? Which metrics are you willing to assume responsibility for given the support structures that the regional entity and state wide entity are likely to be able to provide to you?
144. There are a variety of types of primary providers in Colorado: FQHCs, rural health clinics, philanthropically supported clinics and private practice providers. How should the regional entity RFP and PCMP contractual requirements be structured to assure optimal cooperation and minimal financial competition between provider groups/systems?
145. Would you be willing to expand office hours and/or coordinate with other PCMPs to provide after-hours and weekend coverage as a condition of participation? What extra time beyond weekday daytime hours would you be willing to work?
146. Would you be willing to have some same-day appointments reserved for Medicaid clients?
147. Some providers (FQHCs in particular) have open access/walk-in approaches and have de-emphasized formal scheduling systems. Should these providers be excused from the reservation requirement? Should a different kind of requirement take its place?
148. Do you use other Web-based services currently? Do you have a preference on which statewide Web-based application to adopt?
149. In what area do you most want support and/or feedback?
150. What additional information would you like the statewide Data and HIT entity to supply to you? What do you want to see in a web application?
151. Will this model generate more participation interest on part of PCMPs? If not, what incentives or design would generate the most participation from PCMPs?
152. Should client self management support (behavior modification and self-efficacy for clients through education materials, tools, counseling, group visits, etc.) be a function performed by the regional entity, the PCMP or both?
153. What quality areas are most important to measure in order to inform performance incentives? What other quality measures should the Department adopt that might improve health care delivery, or promote good health, beyond the ones proposed here?
154. What other areas can be addressed that might provide additional cost savings?
155. If PCMPs decided to handle the care-coordination instead of the regional entities, how much PMPM associated with this task that would otherwise be part of the regional entities contract should be made available for the PCMPs? Is this something that should be fixed by the Department contractually, or should the PCMP and the regional entity contract for this on their own? If the PCMP assumes the care coordination function, are

you still willing to enter this information in the state-wide Web application so that it is available if your client changes doctors or moves out of your region? How should data entry requirements be monitored?

156. Would you be willing to accept automated enrollment/direct assignment of new clients to your practice? How many clients would you accept each month?
157. Would you be willing and able to use one or more of the following Web-based applications:
 - a. Web look-up to see all prescriptions the client has purchased through Medicaid in the past X months?
 - b. Web look-up to see laboratory tests and values?
 - c. Web look-up to see what ER, hospital and physician usage the client has received?
 - d. Web look-up of a client registry (recording social services access, social services contact information, cultural demographics, inoculation information, etc.)?
 - e. State financed Web page for each participating provider showing office location, contact information, physician picture, staff information, specialty information that can be browsed by client's looking for a doctor?
 - f. Web entry of some clinical information? Allergies?
 - g. Electronic prescribing?
 - h. Telemedicine?
158. What kinds of technological advance or reform would you prefer the Department to achieve first? Email? Telemedicine? Payment reform? Text messaging? Other?
159. What kind of special tests or comprehensive assessments (beyond the established EPSDT developmental tests in CPT 96110), such as special developmental, functional or cognitive, would you like the regional entities to be able to perform on your behalf?
160. What social services or other kinds of assistance would you like the regional entities to be able to provide to you and your clients?
161. While the Department is envisioning a Web-based application to provide PCMPs with data at the point of care, should the Department also be envisioning portable device support like an iPhone or Blackberry application? If so, which platform? Would you be willing to pay for the portable application to defray the porting costs?
162. What is the cost to you to implement this program?
163. Should after-hours telephone coverage be regionalized so that professional nurse advice is available for all PCMPs, and so that after-hours referral services can assist clients to find a then-open PCMP who can see the client in lieu of going to the emergency room?

The Accountable Care Collaborative will build upon the Colorado Medical Home Standards developed in collaboration with the Medical Home Initiative housed in the Colorado Department of Public Health and Environment and adopted by the Medical Home Initiative Advisory Board. The standards were created in compliance with CRS 25.5-1-103(5.5) and CRS 25.5-1-123(1)-(3) as first legislated in SB07-130, also known as the Medical Home bill for children. These Standards can be found in Appendix C.

164. The Standards were designed for children. Do you see any issues with expanding their application to adults as well?
165. The Department anticipates the regional entity and the statewide Data and IT entity would have the ability to turn on and off the automated enrollment of clients with particular PCMP, and the ability to recommend, for cause, that a PCMP not participate in gain sharing. If the Department adopts a model contract with these provisions, would you agree to use it?
166. Providers, would you be willing to use a web based appointment system in one or more of the above described capacities?
167. Would you participate in making some appointment slots available on the Web so that emergency room providers could directly schedule follow-up appointments with you for your clients? Would you allow the Department or the Department's enrollment broker to see these appointment to assist clients to find an opening immediately?
168. What percentage of your clients have access to, and would use, a web-based appointment application? Would you permit clients to look up your available appointments themselves and to make their own appointments with you without calling your office staff?
169. Would you be willing to use the Web look-up and posting of your open appointment slots if it didn't require any integration into your existing appointment systems?
170. Would you like the ability to choose which entities could view your appointment slot information: Enrollment broker, Department customer service, ER department personnel, fellow PCMPs, specialists, social services agencies, the client, etc.?

The Department, in partnership with CDPHE, CCHAP and other organizations, has a Medical Home Initiative where pediatricians and family physicians statewide have agreed to adopt collaboratively created Medical Home standards in exchange for increased fee-for-service reimbursements on some services.

The transition is envisioned to move willing Medical Home certified doctors and all of their clients into the program practice by practice. These Medical Home Certified doctors (private practice providers are accustomed to calling this CCHAP) would continue to receive their increased fee-for-service reimbursement (if budget allows) for at least the first six months after the start of participation in the Accountable Care Collaborative program. In addition, Medical Home certified doctors would not need to undergo any program practice redesign exercises or requirements and would be "grandfathered" into the Accountable Care Collaborative without these additional requirements.

171. If you are currently seeking medical home certification (in private practice this is customarily called CCHAP), would you continue to do so if the increased fee-for-service funding is available through December 2010
172. What would make the transition from the “medical homes for children” program (involving HCPF, CCHAP, CDPHE, Family Voices of Colorado and other organizations) go smoothly for the patients and the practices?
173. If you are a current Medical Home practice, are you interested in participating in the Accountable Care Collaborative? Why or why not?

The Department is considering empowering pharmacists to allow exceptions to the state's formulary based upon Department sanctioned criteria. For example, if the formulary reimburses only a generic version of a prescription, but it is known that 1 percent of clients find the generic less efficacious than brand, the pharmacist would have the power to provide the name-brand drug when the generic has been tried and failed. To give the necessary information to the pharmacist to make this kind of determination, the PCMP would have to record what drugs have been tried and failed on a Web based application that the pharmacist could view.

174. In exchange for removing the burden from the PCMP to obtain off-formulary prescriptions for clients, would you be willing to access a Web-based application and record your client's prescriptions and their effects?
175. Should pharmacists assume the PCMP's duty of medication reconciliation and medication management? Is this a core PCMP function, or one which can and should be delegated to pharmacists?
176. What would make e-prescribing desirable to you? How can we design on-line formulary access to make your prescribing more efficient? Would an on-line look up of the Medicaid formulary be useful to you?

The Department is interesting in creating a Web-based blogging environment for PCMPs in the Accountable Care Collaborative (e.g. a yahoo or Google group forum where participants can post general questions and concerns, and get prompt replies from knowledgeable persons). It would be moderated by regional organization employees and the Department so that when you raise issues, they would be responded to promptly and publicly.

177. Would you find this new way of communicating with the Department to be desirable?
178. Blogging software allows users to create groups and forums on-the-fly. Would you participate in peer-to-peer communications with other PCMPs in your region?

15.6. Questions for Specialists, Hospitals, Pharmacies, Home Health Providers, Nursing Facilities and other Medical Providers

Specialists, hospitals, pharmacies, home health providers, nursing facilities and other providers will play a key role in the development and delivery of services and common care programs for clients. The Department envisions these providers to be active participants in the Accountable Care Collaborative. The Department recognizes that PCMPs cannot be responsible for coordinating all aspects of client care. Therefore, in order to be successful, all medical providers must have stake in shared goals and participate in the sharing of savings.

179. How do members of the provider community come together to form partnerships and work with regional entities to create a collaborative delivery system.
180. What type of technical assistance would be needed to support community providers in forming partnerships and negotiating active roles within the regional entity?
181. As a community medical provider what is your level of interest in participating with the regional entities?
 - a. How do you view your role in this relationship?
 - b. How do you want the regional entities to include you?
182. As a community medical provider have you taken any steps to work with other medical providers toward partnering with a regional entity?
183. How can regional entities identify providers in local communities that may be interested in participating in the Accountable Care Collaborative, since the Department expects regional entities to collaborate with the rest of the provider community?
184. How can the regional entities establish relationships with the rest of their provider community? Should the Department require formal relationships in the form of written contracts?
185. How can community providers be aligned with regional entities to achieve program objectives and share in financial incentives?

The Department recognizes that physicians and primary care providers collectively deliver a small portion of services financed by Medicaid. Hospitals, pharmacy, home health, nursing homes, DME, counties and scores of providers deliver and must collaborate to coordinate activities to maximize the health of clients. The regional entity is charged with developing compacts and coordinated efforts to ensure seamless, efficient and effective care. The model of medical home yields to a vision of a healthy community. The Department aims to stitch a quilt up community based providers rather than provide an additional uniform blanket of services. Many providers have care coordinators, discharge planners and social workers who would now have easier access to other providers supported with data and clearer expectations.

186. Would you be interested participating in the Accountable Care Collaborative as described herein? Please identify yourself or your organization. What is your current relationship with the Medicaid program?
187. What kind of coordination should the Department require the regional entities to perform with you and your programs?
188. Are there coordinating functions that the Department should withhold from the regional entities so that you can do these functions without additional encumbrance or difficulty from the regional entity?
189. How can the regional entities help you to perform your functions better? Are there functions or requirements that the regional entity can/should perform to enhance the effectiveness of your programs?

190. Do you have a preference on the Web-based solutions, or particular Web applications that might integrate better with your own?
191. The Department anticipates that the statewide Data and HIT entity will construct a Web-based application that will give medical and non-medical persons access to appropriate information about the client. For example, social services organization, specialists, and other persons might be interested in accessing the regional entity maintained cultural dossiers on acceptable behaviors, courtesies, customs and expectations which are unique to families of specific cultures and ethnic groups. Would you be willing to access the Web-based application and add some data about your interactions with the client to inform the PCMP and other authorized viewers about your activities? The concept is to offer the PCMP a 360 degree view of their client's medical and social needs, on a one-stop shop, to better inform PCMP care and treatment. Are you willing to do some data entry for your clients to meet this goal?
192. Would your program like to participate in the web-based appointment application so that physicians could directly set up appointments with your coordinators and contractors? Would you like access to the application to set up PCMP appointments for your clients via the Web?
193. There are a variety of types of primary providers in Colorado: FQHCs, rural health clinics, philanthropically supported clinics and private practice providers. In order to provide access to all Medicaid clients, all of these provider types need to work collaboratively and cooperatively, in order to be successful. What systems will be required to assure optimal cooperation and minimal financial competition between the various provider groups/systems?
194. What additional IT and other resources might be required to meet these child-specific Medical Home outcome measurement standards?
195. What restrictions, if any, are on your ability to share information with other entities (federal regulations, state law, board restrictions by-laws, restrictions by funders, etc.)? Can these restrictions be overcome if the client consents to the sharing?

The Department is interested in maximizing the *health, functioning and self-sufficiency* of all clients, as well as assuring that clients receive good health care when they are sick. Some of the metrics of good health include: physical and mental health assessments, health related days of missed school, functional assessments, suicide rates, rates of physical assault by current or former intimate partners, DUI rate; sexual violence rate; school violence rate; child abuse rate and metrics related to healthy lifestyles and risk factors include obesity rate, smoking rate, drug and alcohol abuse rate, physical activity, binge drinking rates, etc.

196. What are population health and risk factor metrics that you would suggest?
197. The Department recognizes the role *promotoras* and lay community health educators have made in improving health of vulnerable populations; are there existing services that could be funded through this initiative that would promote these activities for Medicaid clients?
198. What services do regional public health offices provide that could be coordinated or supported through the regional collaboratives to promote client health?

199. Which sets of published data or surveys do you recommend the Department adopt as the way to measure the above population health metrics in your region? Do these measures provide you with enough data, in a timely enough fashion, to enable you to monitor and react to poor population health trends within a contract year? If not, how long of a monitoring cycle would you need to validate the outcomes of your interventions?

200. What else would you like to see addressed?

15.7. Questions for All Interested Participants

201. Please identify yourself and any organization you represent. What is your current relationship to the Medicaid program?

202. What functions are most appropriate at the regional and state level? Which functions should remain at the network level? Is the implementation of the start of this program too fast? If so, what elements are most essential, and feasible, to achieve in the implementation timeline?

There already exists a statewide care coordination collaborative for children, which has been developed by HCPF and CDPHE. It is organized around Senate Bills 07-130 and 07-211 and the medical homes for children standards. Developed over a long period of time by Department personnel, CDPHE and 40-50 community-based organizations and county agencies the program that includes: incentives that promote preventive care and care coordination; practice supports; practice evaluation; and processes to improve performance. This effort now includes over 100 practices and clinics and approximately 120,000 Medicaid and CHP+ children.

203. If the medical home program for children is moved into the Accountable Care Collaborative, what would make the transition from the “medical homes for children” program go smoothly for the clients and the practices?

204. Are there organizations or services that should be recommended to the regional entities to assist them in implementing the medical home quality of care for children?

205. Which support services should be provided by the regional entities, and which services should be provided centrally to enable the PCMPs to meet the standards?

206. What organizations should the Department require the regional entities to partner with in order to make care for children comprehensive and high quality?

The Department is building this program influenced by North Carolina’s PCCM model, Colorado’s Medical Home for Children program, and NCQA’s Physician Practice Connections - Patient-Centered Medical Home. However, other states have adopted models with only one or two statewide regional entities administering a care management program. Vendors in these states assert that one or two entities can provide various managed care tools, such as evidence-based guidelines, timely communication of prior authorization and pharmacy information to the client’s care team, health risk assessments, disease management programs, case management protocols and successful emergency room diversion programs, among others, to the benefit of not only clients, but also other stakeholders as well.

207. Is state-wide efficiency and consistency more valuable than local PCMP influence and control? Do you prefer the regional model, or the two-entity competitive model? Why?

208. The Department currently offers a 24/7 nurse advice line to all FFS clients through a state QIO contractor. Should the Accountable Care Collaborative assume this function at the regional level, the state level or should it be left where it is?
209. How should the Department construct the program to minimize unintentional harm to already existing local centers of excellence?
210. Should the dual eligible population be included in the program given the fact that the dual eligible population requires a different and more intensive set of services than other Medicaid populations? If so, under what structure this should occur?
211. The literature on value-based purchasing indicates that in order to incentivize changes at the provider level, a significant portion of the provider's patient panel must be subject to the incentive. How can the Department align the Accountable Care Collaborative with similar efforts from other payers? How can the program structure at the regional or statewide level be made more inclusive of or dovetail with efforts by other payers?
212. What needs to be changed or remedied with Medicaid processes or procedures before the Accountable Care Collaborative is instituted?
213. In what way(s) will the creation of the Accountable Care Collaborative create duplication of efforts and how can duplication of efforts and services be avoided?
214. How can HCPF ensure that all appropriate current effective community-based organizations are appropriately included?

The Department is considering a rigorous evaluation of this initiative. The evaluation would definitely take place during the pilot phase and help determine whether performance has been achieved to trigger population expansion.
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215. Should the Department procure a separate third party evaluation? Or should evaluation be a requirement of the central organization?
216. What are the key considerations in designing the requirements for the evaluator?
217. At what stage of the initiative should the evaluator be selected? Should a contract be in place prior to the contracting with the regional entities to allow for participation in metric selection?

16. Compensation Overview

The total estimated funding (exclusive of medical costs and gain-sharing payments) for the first year of this program, for all operating regional area contracts and the state-wide IT contract, is \$14,400,000 (60,000 clients per month cap, \$20 PMPM, twelve months). If the program is successful, the potential number of clients enrolled could reach 350,000 to 400,000.

From the total budget, the Department must fund the regional entities, the statewide Data and HIT entity and the participating PCMPs. The program must be at least revenue neutral to be considered successful. Revenue neutral means that the costs associated with the program are offset by equal or greater savings in medical costs. It is not known what would happen to the

program should it not attain revenue neutrality in the first fifteen months of operation (the last three months of State Fiscal year 2010, plus all of State Fiscal Year 2011).

The Department anticipates, for the first year, a gain-share incentive pool. The savings would be based upon benchmarks established at the beginning of the contract based upon a control group, or local experience, or some other actuarially sound method.

No incentive payments would be paid if the program was not, globally, revenue neutral (even if savings could be demonstrated in one of the measures, such as reduced ER utilization).

Because the incentive program is likely to compare program medical costs against FFS medical costs, PCMPs cannot treat some clients in FFS and others in the Accountable Care Collaborative. (It creates a counter incentive for PCMPs to manage their FFS poorly so that their Accountable Care Collaborative enrolled clients appears to be healthier and thus earn gain-share and other incentive payments.)

PCMPs would receive from the statewide Data and HIT entity a monthly or quarterly statement showing PCMP performance on the quality and cost saving measures, the amount earned in incentive pools, the overall performance in the region and other metrics. The continual feedback will offer the PCMPs and the regional entities an opportunity to make changes to early poor results in sufficient time to turn around the numbers.

Base Payment Overview

The statewide Data and HIT contract is envisioned to be a competitively bid fixed-price contract with some incentives if the regional entities and PCMPs achieve cost savings and quality goals.

The regional entity contracts are envisioned to be competitively bid rate-based contracts, with a monthly PMPM payment determined by monthly client enrollment in the region. The regional entities would be eligible for incentives if they achieve cost savings and quality goals.

The PCMP contracts are offered to any willing provider.

Procurement

The contracting process will be staggered. It may be necessary to have multiple best and final offer submissions (for revised statements of work and budget) so that the Department can manage the regional entity solicitations and the statewide Data and IT entity solicitation within the budget. The Department intends to obtain the best combination of services within the available budget.

Payment Models

The Department is considering different payment models for PCMPs. The first pays additional PMPM to PCMPs that exceed basic practice characteristics. For example, in addition to a base \$1 PMPM, the PCMP might receive an additional 25 cents for having and using EMR technology, an additional 25 cents for having a larger percentage of Medicaid clients than average, an additional 25 cents for doing some registry data entry of clinical findings, and additional 25 cents for having very extended office hours or for being open on weekends, etc. Under this model, PCMPs are incentivized for certain activities or characteristics on a pay-as-you-go basis. The incentive pool would consist of some additional gain-share for actual proven cost savings in ER visits and hospital admissions which would be distributed proportionally

based on each PCMPs client member months for the year if the PCMPs achieve the cost savings or quality goals.

Under the second model, PCMPs would receive a base PMPM of \$1, but up to an additional \$3 would be put into a larger PCMP incentive pool, plus any gain-share for cost savings in ER visits and hospital admissions. (A \$3 incentive pool is \$ 2.1 million, if all 60,000 clients are enrolled with a PCMP, not including any gain-share savings.) Assuming the collective PCMPs achieve cost savings or quality goals, those PCMPs who contributed more to those goals would get a larger share of the incentive pool. PCMPs that contributed less would receive less (or none).

The first model is a fixed pre-pay model with more limited incentive opportunities. PCMPs know in advance what they will earn during the year by taking their client load and multiplying it by their earned based rate. There is no risk, and limited upside end-of-the-year gain.

In the second model, PCMPs would receive a smaller guaranteed PMPM, but in exchange they would have the opportunity to share in a larger incentive pool. Higher performing PCMPs would earn a larger percentage of the incentive pool (more than just the sum of the deferred PMPM payments of the first model) than would poor performing PCMPs. This model creates PCMP cooperation (work together to achieve global savings) and competition (do it better than fellow PCMPs to earn a higher percentage of the incentive).

The Department is also considering to two different incentive models for the regional entities. Both models place \$1 or \$2 into a regional entity incentive pool, plus some additional gain-share for actual proven cost savings in ER visits and hospital admissions. The total of all incentive payments cannot exceed 5% of the total paid medical costs plus PMPM payments to the PCMPs and regional entities and the Department is exploring with CMS whether gain sharing can exceed this limit and whether a waiver would be necessary.

In the first model, the regional entity would receive the incentive pool earned in that region if the local PCMPs achieve the cost savings or quality goals. This model offers the regional entity a powerful incentive to help the PCMPs succeed.

In the second model, all the regional entities would pool all incentive pool monies earned in all regions *together*. The regional entities that meet the cost savings or quality goals would participate in the pool disproportionately; those with the best performance would receive a larger share, those with the poorer performance a lesser share. This model offers the regional entity an incentive to not only to help local PCMPs succeed, but also to perform better than the sister regional entities.

The Department envisions offering performance incentives to the regional entities. Under consideration are that cost savings must recoup all PMPM payments before payout to anyone (revenue neutrality).

Incentives would be distributed yearly, after 90 days claims lag and with an amount withheld to account for possible seasonal variance. Incentives would be lost if some quality metrics or other kinds of metrics fail, even if savings actually accrue.

The regional entities might forfeit some or all incentives if they fail to achieve satisfactory outcome measures. For example, if their client voluntary disenrollment rate was above a target attrition rate probably means that clients do not have reasonable access or are otherwise dissatisfied with the PCMP.

The regional entities would be required to reinvest a yet to be determined amount into the local community. Some of these monies would be required to be invested in additional Web-application expansion and improvements.

The Department is considering a gain sharing with the regional entities on savings; the gain sharing represents another pool of incentives that allow for alignment of activities towards program goals.

17. Compensation Inquiries

218. Would a 30% or 50% gain sharing on savings be adequate to motivate PCMPs and regional entities? What would be the advantages or disadvantages?
219. We are considering including the dual-eligibles with two objectives – discussions with CMS around gain sharing on the Medicare savings as is done in the CMS 646 Demonstration and also having the regional entities optimize the resource utilization for long term care services that are Medicaid funded. Comments?
220. The literature on value-based purchasing indicates that in order to incentivize changes at the provider level, a significant portion of the provider's patient panel must be subject to the incentive. Should the Department align the Accountable Care Collaborative with similar efforts from other payers? How can the program structure at the regional or statewide level be made more inclusive of or dovetail with efforts by other payers?
221. PCMPs: which PMPM model do you prefer; large PMPM/small incentives or small PMPM/large incentives?
222. Regional entities: which incentive model do you prefer; single region pool, or combined region pool?
223. Given the broad scope of duties described here, is it operationally and financially viable to start with multiple regions simultaneously, given a total enrollment cap of 60,000 clients? (Regional entities may be allowed to be awarded more than one region.) Are the incentives strong enough, and client pool large enough, to motivate the formation of a regional entity to participate, given the costs that would be involved in establishing such an entity? If not, what enrollment census or changes are necessary to be operationally and financially viable? What is the optimal number of regions to take advantage of the economies of scale?
224. The Department is likely to require that a PCMP have a minimum number of Medicaid clients (5% of the practice) in order to participate in the incentive program and thus encourage PCMPs to increase their Medicaid practices. Will this work? If not, what will? Is five percent the right percentage? Does the percentage need to vary by practice area (rural vs. urban) or by other characteristics? What are they?
225. Would PCMPs participate in the program without any base PMPM (and thereby solve the Department's programming quandary to restore PMPM functionality in MMIS) if the gain-share savings contributed to the incentive pool were very generous (e.g. equal to 50% or more of inpatient and ER savings)?

226. What suggestions do you have for incentivizing PCMPs to use the information and resources made available through this statewide Data and IT entity?
227. The Department envisions paying all PCMPs the same PMPM amount for each client. A variable PMPM is also possible, based upon risk scores, aid categories, age, or other characteristics. Recognizing that this is a zero-sum area (an increased PMPM for disabled clients means that the PMPM for other clients must be reduced) which method is preferred? Flat rate or variable rate depending on client characteristics?
228. What other observations and comments do you have about the compensation scheme?

18. Glossary

AHRQ — Agency for Healthcare Research and Quality. <http://www.ahrq.gov/>

AIRS — A credentialing authority operating an Accreditation Program that measures an organization's ability to meet the AIRS Standards for Professional Information and Referral. There are 28 standards. <http://www.airs.org>

Alternative Care Facility — A residential facility which provides a package of personal care and homemaker services and protective oversight to eligible persons, which meets applicable state and federal requirements, and which is state-certified.

Analytics — the study of data using statistical analysis in order to discover and understand historical patterns with an eye to predicting and improving business performance in the future.

BHO — Behavioral Health Organization. The Department contracts with five capitated managed care plans to provide comprehensive mental health services to all Medicaid clients.

BLOG — (a contraction of the term "Web log") is a Web site, usually maintained by an individual with regular entries of commentary, descriptions of events, or other materials.

BRFSS surveys —Behavioral Risk Factor Surveillance System. A state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury.

CAHPS — The Consumer Assessment of Healthcare Providers and Systems. A comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services.

Care Coordination — "Care coordination" is a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which a client's needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care. "Care coordination" encompasses both health care and social support interventions across the range of settings from the home to ambulatory care to the hospital and post-acute care.

CCGC — Colorado Clinical Guidelines Collaborative which brings health plans, physicians, hospitals, employers, public health entities and others together with the mission to implement evidence-based guidelines, protocols, and systems to improve prevention, early detection, and treatment of chronic diseases such as cardiovascular and pulmonary disease. CCGC was established in 1996 for the expressed purpose of achieving consensus from multiple stakeholders to develop uniform guidelines for the entire state.

CCHAP — Colorado Children's Healthcare Access Program. Additional information on this program can be found at <http://www.cchap.org/>

CHA — Colorado Hospital Association

Child Find — Child Find is a component of Individuals with Disabilities Education Act (IDEA) that requires states to identify, locate, and evaluate all children with disabilities, aged birth to 21, who are in need of early intervention or special education services.

CLAS — Culturally and Linguistically Appropriate Services. The fourteen CLAS standards are primarily directed at health care organizations. They are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations. The Federal government requires all recipients of Federal funds to comply with Standards 4, 5, 6, and 7. The Department encourages adoption of Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13.

Standard 1

Health care organizations should ensure that clients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2

Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3

Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4

Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each client/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5

Health care organizations must provide to clients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6

Health care organizations must assure the competence of language assistance provided to limited English proficient clients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the client/consumer).

Standard 7

Health care organizations must make available easily understood client-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8

Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9

Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, client satisfaction assessments, and outcomes-based evaluations.

Standard 10

Health care organizations should ensure that data on the individual client's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11

Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12

Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and client/consumer involvement in designing and implementing CLAS-related activities.

Standard 13

Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by clients/consumers.

Standard 14

Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

CMS — Centers for Medicare and Medicaid Services.

CORHIO — Colorado Regional Health Information Organization

CPI — Consumer Price Index

DHS — Department of Human Services

DPHE — Department of Public Health and Environment

Dual eligible — Dual eligibles are individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.

ePCCM — Enhanced Primary Care Case Management

EPSDT — Early and Periodic Screening, Diagnosis, and Treatment program promulgated by the Federal Government

EQRO — External Quality Review Organizations referred to in 42 CFR 438.310, *et seq.*

ER — Emergency Room

FFS — Fee for Service (“Regular”) Medicaid

FQHC — Federally Qualified Health Center (federally designated nonprofit or public health care entities that provide comprehensive primary care services regardless of ability to pay)

HCBS — Home and Community-Based Services. Home and Community Based Services are sometimes called Waiver Funded Services or Waiver Programs because they are provided under special conditions through federal approval whereby certain rules for Medical Assistance eligibility are waived. HCBS provide services beyond those covered by the Medicaid program that enable individuals to remain in a community setting rather than being admitted to a Long Term Care Facility. If an individual is determined eligible for more than one HCBS program, the individual cannot receive services under two or more such programs at the same time. The person must choose one HCBS program and receive the services provided by it.

HEDIS — Healthcare Effectiveness Data and Information Set. A tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. <http://www.ncqa.org/tabid/59/Default.aspx>

High risk client — clients at substantial risk of hospitalization in the coming year, but not necessarily those with greatest risk for repeated hospitalizations. (While clients with the highest risk of multiple hospitalizations and extreme costs might be thought to provide the greatest opportunity for savings through care coordination, in some cases these clients have diseases that have progressed so far that improving care coordination services will not reduce the likelihood of a hospitalization.

HIPAA — Health Insurance Portability and Accountability Act of 1996 and the privacy and security regulations promulgated under it.

HIT — Health Information Technology. Systems that allow for the comprehensive management of medical information and the secure exchange of data and records.

IPA — independent physician association

IPIP — Improving Performance in Practice Initiative. An initiative by the Colorado Clinical Guidelines Collaborative (CCGC) on practice coaching and redesign.

Local center of excellence — A group of people that promote collaboration and using best practices to improve health and health care.

MMIS — Medicaid Management Information System. The Department's claims payment system.

NCQA — National Committee for Quality Assurance

NCQA accreditation — Accreditation by the National Committee for Quality Assurance certifying the quality of the key systems and processes that define health care organizations. Accreditation includes an assessment of the care and service that plans deliver in important areas like childhood immunizations. NCQA began accrediting managed care organizations in 1991.

Outcomes-focused contracting — An outcomes-focused contract provides payment, depending not upon the number or frequency of services provided, but upon successful achievement of a goal. For example, under the Department's existing managed care contracts, contractors are required to have an adequate provider network, which is often defined as a ratio of providers to clients. Network changes and adequacy are reported. The Department monitors the reports. In an outcomes-focused contract, the Department would emphasize access, not ratios. There are many ways to do this. One could be based upon monitoring the time between when a client seeks care and when they receive it. If the average duration is short, and the outliers few, it is reasonable to assume the network is adequate. If the average duration is long, and/or there are many outliers, may be reduced and enrollment would cease.

Part C — Individuals with Disabilities Education Act (IDEA) Part C: Special Education Grants for Infants and Families with Disabilities. An early intervention special education program to provide services to infants and toddlers ages 0 to 36 months who are developmentally delayed or at high risk for a developmental delay.

PCCM — Primary Care Case Manager. A federally approved managed care model described throughout 42 CFR 438.

PCPP — Primary Care Physician Program

PCMP — Primary Care Medical Provider

PDQA — Product Development Quality Assurance

PMAG — Performance Measure Advisory Group. A committee required by SB07-211 to establish pediatric health outcomes standards.

PMPM — Per Member Per Month (a per capita administrative fee)

PQI — Prevention Quality Indicators. The Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care-sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

The PQIs are a software tool distributed free by AHRQ. The software can be used to help hospitals identify quality of care events that might need further study. The PQI software programs can be applied to any hospital inpatient administrative data.

PRAMS — Pregnancy Risk Assessment Monitoring System. A surveillance project of the Centers for Disease Control and Prevention (CDC) and state health departments. PRAMS collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy.

Program — A short-hand reference to the Accountable Care Collaborative.

Promotora —an outreach worker in a Hispanic community who is responsible for raising awareness of health and educational issues.

QIO — Quality Improvement Organizations. CMS contracts with one organization in each state, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands to serve as that state/jurisdiction's Quality Improvement Organization (QIO) contractor. QIOs are private, mostly not-for-profit organizations, which are staffed by professionals, mostly doctors and other health

care professionals, who are trained to review medical care and help beneficiaries with complaints about the quality of care and to implement improvements in the quality of care available throughout the spectrum of care.

Registry — An organized web-based system to collect uniform client data (clinical and other) on a particular disease, condition, or exposure, and that serves one or more predetermined scientific, clinical, or policy purposes.

Residential Care Facility — a residential facility that makes available personal services; protective oversight; social care due to a client's impaired capacity to live independently; and regular supervision available on a twenty-four-hour basis, but not to the extent that regular twenty-four-hour medical or nursing care is required.

RFI — Request for Information.

RFP — Request for Proposals.

Rural Health Care Pilot Program — In cooperation with the Colorado Hospital Association (CHA), this program is an enhanced funding initiative intended to help public and non-profit health care providers construct state- and region-wide broadband networks to provide Telehealth and telemedicine services throughout the state.

SEP — Single Entry Point agencies determine functional eligibility for community based long term care programs, provide care planning and case management for clients in these programs, and make referrals to other resources.

Small group practices — Individual PCMP practice, small partnerships, clinics with several PCCMs.

SSI — Supplemental Security Income. A needs-based cash assistance program. SSI is for people with limited income and assets. Adults can get SSI if they are age 65 or older, disabled, or blind. Children can get SSI benefits because of disability or blindness.

TCM — Targeted Case Management services are those aimed specifically at special groups of enrollees such as those with developmental disabilities or chronic mental illness, or to individuals who reside in specified areas of the state. Services include assessment of an eligible individual; development of a specific care plan; referral to services; and monitoring and follow-up activities.

Value-based care — A system that promotes value (an effective intervention that reduces total Medicaid expenditures for the participating clients at least enough to cover intervention costs, while maintaining or improving client outcomes) encourages collaboration and shared responsibility among providers. Shifting the emphasis from volume and intensity of services to incentives for efficiency and quality.

Virtual Network — An interconnected group of individual PCCM practices, PCCM partnerships, clinics and common-ownership enterprises that appears to be one large single network to the client. From the provider perspective, the virtual network enables providers to communicate with each other transparently and simply through a consistent web based user interface so that each provider has, at the point of service, information about all the other services previously offered to the client anywhere else in the network.

Whole person centered — Health care that focuses on improving a client's health and wellbeing by addressing the client's physical health (body), mental/psychological health (mind), the mind-body connection and the client's life situations (e.g. disabilities, isolation, helplessness, etc.).

WIC — The Special Supplemental Nutrition Program for Women, Infants, and Children - better known as the WIC Program - serves to safeguard the health of low-income women, infants, & children up to age 5 who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care.