



**COLORADO**

Department of Health Care  
Policy & Financing

## **MINUTES FOR THE ACC Program Improvement Provider & Community Issues Sub-committee**

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

April 16<sup>th</sup>, 2015

### **1. Introductions**

#### **A. In-person Attendees**

Aubrey Hill (CCMU), Josie Dostie (CCHA), Todd Lessley (Salud), Anita Rich (CCHAP), Matthew Lanphier (HCPF), Barb Martin (CDPHE), Kathryn Jantz (HCPF), Erin Miller (HCPF), Carole Saylor (Rocky Mountain Youth Clinics), Elizabeth Erickson (CCHA), Lila Cummings (HCPF), Marija Weeden-Osborn

#### **B. Phone Attendees**

Ken Davis (Mountain Family), Molly Markert (COA), Brooke Power (ClinicNet), Pamela Doyle, Elizabeth Forbes, Jill Atkinson, Jessica Provost (ICHP), Heather Logan (MCPN), Donald Moore (PCHC), Kelley Vivian (RCCO 7), Shera Matthews, Nicole Zenck, Kristin Trainor (CCHA), Elizabeth Forbes

### **2. Announcements**

There were no announcements this month.

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

Minutes were approved.

### **4. Consumer Input/ Client Experience**

There were no updates regarding consumer input this month.

### **5. Workgroup Reports (Map)**

Todd: PIAC discussed criteria for deciding what the new RCCO map regions should look like. We as a sub-committee volunteered to look at that issue and make some recommendations regarding those criteria. We started discussing from that

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perspective, and then made the decision to focus instead on principles that should be considered before any map revisions are considered. Matt sent out a memo with the handouts summarizing those principles. Yesterday HCPF approached us and asked them what our position was. We didn't want to come forward with a formal stance until we vetted these principles with the broader sub-committee. These principles are a reflection of the work the workgroup has done and not necessarily reflective of the broader sub-committee.

KJ: We're being pressured by external stakeholders to make a decision on the map, and our executive team has decided to move very quickly. We are asking for input regarding a proposal framework that may be in place by next week. There will be a need for continuing engagement and input on this process, but we will be giving an indication of where we're moving on this.

Todd: Can you talk about where these stakeholders are coming from and why the pressure is increasing at this point?

KJ: It's coming from our RCCO and BHO partners who want an indication as to where we're headed. Gretchen, our new director, is also committed to maintaining the department's commitments and we had said we would give an indication about where the system is headed by April. We are planning on moving towards one administrative entity for both RCCOs and BHOs.

Todd: Todd went through and listed the principles for map revisions. Does anybody have questions about those principles or how we arrived at those principles?

Casey King: One thing I noticed was not part of the principles was the ability for RCCOs to overlap, so we're locking ourselves into the regional model. It looks like we're suggesting to continue the regional model as it exists?

Anita: That was a discussion. Some folks, particularly in the urban/suburban part of the world cross boundaries often, and the fourth bullet addresses this in some way by asking that the decision be data driven and should examine access patterns and such.

Ken Davis: Can we include in the fourth bullet something about allowing the client to choose the RCCO that best suits their needs or something?

KJ: I don't think it's mutually exclusive that we have a regional model and a model that factors in the client's choice of where they get their care. I think the Department is leaning towards one RCCO per region. We want to emphasize partnerships and we don't want too many Medicaid entities competing for these relationships. We understand we have a couple of areas where we need solutions that might be unique and we are considering those solutions. I think there's a lot of



options around attributions and we're not necessarily tied to the current model of attributing based on county of residence.

Casey King: My point was that some of the larger providers have a larger networks that cross over boundaries that creates confusion for our members and we need to figure out a solution for these instances.

Molly: What I hear is that the region, no matter what the geography, needs to have more relevance as far as incentive payments go. It doesn't matter what the geography is, it matters what the purpose of a region is from a PCMPs point of view.

Anita: There isn't a level of relevance to geographical regions when a PCMP draws from a bunch of regions. They never get a report regarding what they do, but rather what the regions do.

KJ: I think we'll continue to have a fundamentally regional structure, but there are a lot of decisions to be made and a lot of options that we are interested in exploring.

Casey: Some way of identifying client choice of provider and existing provider networks as a factor above geography in appropriate RCCO networks.

## 6. Workgroup Reports (NEMT)

Molly: We met a few times. Yesterday we came up with a few principles for short term urban solutions. Short term solutions are things the vendor or Department can do now, while long term solutions would require budget or legislative actions. We reviewed the contract, and the contract details a survey of patient and provider satisfaction.

Casey King: What will the process be for working with TT for providers with campus addresses?

Molly: My understanding is that Jeanice had to work with Mapquest directly.

Anita: We should put these recommendations together and have the sub-committee workgroup meet with Total Transit to go over these.

Ken Davis: I would like to motion that we submit these recommendations with the amendment that we have the workgroup meet with Total Transit to go over these recs and that they go over the call script.

Todd: I would also like to include the recommendation that we have a process for elevating complaints to HCPF.



## 7. PIAC Update

Todd: There was a discussion around how often a sub-committee would meet, and the PIAC recommended a standard of 8 meetings at least per year. We received a presentation from the Colorado Opportunity Project. The committee really recognizes there will be a lot of topics around the RFP and the committee set some ground rules around having those big discussions and will keep everyone up to date as needed.

KJ: We are going to be releasing an executive summary of our RFI responses as well as the complete text of all RFI responses, so keep your eyes peeled for those.

## 8. Recommendations Follow-up

#1 will be removed

#2 will stay, the workgroup is working on this.

Lila discussed #3 and the HQIP. There's a couple different measures that we are looking at, and one thing is the hospitals working with RCCOs – we'd like to formalize that process. We're also thinking about how hospitals can be brought in more to the ACC.

KJ: On #4Hospitals can bill different codes for emergent and non-emergent. There is no process for automatically shuffling a claim to non-emergent. It's an interesting topic and we're open to further discussions, but I want to be clear that we do actually pay less for non-emergent ER visits. It might be worth re-visiting the data because we looked a lot into this and have a lot of data. Perhaps we can look at the data and refine the recommendations.

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#2-7 will remain

#8 is removed

Recommendations will be continued next month.

Next meeting 5/21/15.



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