



State Medical Assistance and Services Advisory Council

225 E. 16th Street
Denver, Colorado 80203

March 26, 2014
6:00pm – 7:45pm

MINUTES

ATTENDING:

Council Present: Robert Bremer, Andrew Davis (via phone), Peter McNally, An Nguyen, Ruth O'Brien, Blaine Olsen, Nancy Stokes (via phone), Louise Vail, Victoria Vowel, Blair Wyles

Council Absent: J. Scott Ellis, Rebecca Lefebvre, Theresa McCoy, Mark Thrun, Judy Zerzan

HCPF Representatives: Jeannette Jansson, Patricia Connally

CDPHE Representative: Steve Holloway

HCPF Presenters: William Heller, Zack Lynkiewicz, Dustin Moyer, Kimberley Smith, Van Wilson

Guests: Beverly Skram

Meeting called to order at 6:00 p.m. February minutes were approved. Peter McNally commented that in the future it is important when requesting the council to contact constituents, get support for projects and/or commit their time to a project, then we should be prepared and have the appropriate information and or websites in place. When preparation is not made we lose credibility and interest as does the department.

Department updates since February meeting minutes:

The JBC approved rate increases and the .5% targeted rate increases and the implementation date is July 1st if approved by the governor.

Project Extension for Community Healthcare Outcomes (ECHO) is moving forward – department staff are working with the university (Jeannette Jansson will be on the advisory committee for medicine, pharmacy and nursing) to create an infrastructure for the ECHO Project and the transition for Colorado to be the hub for the ECHO project.

The implementation of International Classification of Diseases 10 (ICD-10) is scheduled for October 1, 2014. This will involve a lot of changes for the providers, the changes will not be in the policy but in the coding. The department has partnered with Centers for Medicare and Medicaid Services (CMS) for ICD-10 training.

Chief Nursing Officer (CNO)

Jeanette Jansson introduced herself to the council. She has been brought on board as the CNO and will collaborate on providing a clinical voice within the department among the varied programs and organizational forms that the department has. Jeanette comes from Oregon and has a policy background from her work with the Center for Evidence Based Policy on the creation of the Drug Effectiveness Review Project (DERP) and the Oregon Health Plan. Clinical background includes working as the executive level of the Oregon and Health Sciences

University and she worked as a computer executive prior to that. Jeannette's credentialing includes: Registered Nurse, Nurse Executive Certified and Legal Nurse Certified.

Legislative Update

Zack Lynkiewicz presented a legislative update.

SB 14-67 Aligning State Medicaid Eligibility Categories with Federal Law. Signed by the Governor in February.

SB 14-143 Nursing Facility Provider Fee Clarification. This bill clarifies which pot of money the nursing facilities settlements can be paid from. Passed the Senate and will now go on to the House.

HB 14-1308 Extend Over-expenditure & Appropriation Transfers. This bill continues the department's authority to transfer funds to the Department of Human Services (DHS) and allows us to overspend if necessary. This bill has passed out of the House and is moving to the Senate.

Other bills of interest:

HB 14-1115 Medicaid Pilot Program. This bill would require the department to study the cost effectiveness of enrolling Medicaid eligible clients into private health plans through the exchange. The bill passed out of the House Health committee and then died in Appropriations.

HB 14-1051 Developmental Disability Services Strategic Plan. The bill requires the department to create a strategic plan to end the waitlist for Home and Community Based Services (HCBS) waivers. The bill has passed both the House and Senate and was signed by the governor.

Long Bill. The JBC closed the Long Bill and the House will debate it and then it will go to the Senate. The JBC voted to include the majority of the department's budget requests into the Long Bill. JBC approvals were: (1) request for health information exchange network (building interface systems); (2) two percent across the board rate increase for all eligible providers; (3) additional .5% rate increase for providers that work with the developmentally disabled population; (4) targeted rate increases; (5) continues 1202 rate bump-paying primary care providers Medicare rates until 2016; and (6) \$5 million incentive program to recruit more dentists into the Medicaid program.

Dentures as a part of the Dental Benefit.

The Colorado Dental Association championed the drive to get dentures included in the Adult Dental Plan. The JBC agreed to provide additional funding for dentures so it is not subject to the \$1,000 cap.

Marijuana Tax. The budget requests submitted regarding the marijuana tax have not been determined and there are a lot of issues surrounding the funds.

Adult Dental Benefit

William Heller presented on the Adult Dental Benefit. State was to implement a limited adult benefit with the signing of SB12-242. HCPF hired a dentist to establish a base of benefits and put them before stakeholders for discussion. The department hosted seven collaborative meetings with stakeholders to discuss the proposed benefits. The dental benefit is being released in two phases:

(1) April 1, 2014 implementation date for adults over 21 to get basic benefits including restorative and preventative, and diagnostic and minor procedures; and

(2) July 1, 2014 the full benefit package will be available which we hope will also include dentures.

HCPF is currently reviewing bids and hope to have a vendor selected in the next week to develop and implement the full benefit package. HCPF did not have the ability within Medicaid Management Information System (MMIS) to handle a dental program so are buying the services from an Administrative Services Organization (ASO) and also having a developed dental network.

There is \$5 million in dental incentives that will be available July 1, 2014 to get dentists signed up and they have to take a specific number of clients and the department is hoping to get federal matching funds as well.

HCPF submitted a rule before the Medical Services Board which was approved. Final approval will be sought and then another rule will need to be submitted if dentures are to be added. HCPF submitted a State Plan Amendment (SPA) to CMS for the dental benefit and if dentures are added another SPA will be submitted for the denture benefit because CMS sees them as two separate categories.

There is a \$1,000 cap starting on April 1, 2014 for this fiscal year which will end on June 30, 2014 and beginning July 1, 2014 the \$1,000 cap for the next fiscal year will begin. Access to dental services will be through contracted Medicaid dental providers. Link to website for Adult Dental Benefit: <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1251567070354>

Benefit Coverage Standard (BCS)

Kimberly Smith provided a Benefits Collaborative (BC) update. The Office of Legislative Services (OLS) has questioned the validity of the last step in the BC process, "incorporation by reference." In this step we take the Benefit Coverage Standard (BCS) and we incorporate it by reference into Volume 8 rule. In other words, instead of putting the whole standard into rule we put a paragraph in the rule which refers people to the standard that is on our website. The department and Attorney General's Office (AGO) interprets when incorporation by reference may be used one way and the OLS interprets it another way.

The matter went before the Committee of Legislative Legal Services and the department's interpretation of the rule was struck down by the Committee, although they were very supportive of the collaborative process. The department does not have any plans to get rid of the BC process but we did put the process on hold while we determined what the new last step of the process would be.

The department is now planning to translate each BCS into rule language, which is a major formatting and legalese challenge. The department is leaning towards keeping Benefit Coverage Standards as policy manuals while also placing the parts of the standard that define the amount, scope and duration of the benefit into rule.

We will be presenting before the Medical Services Board in April and May to amend the 11 rules that contain standards "incorporated by reference" so that our clients will not experience gaps in services when the repeal of these rules goes into effect.

Integrated Care for Medicare-Medicaid Enrollees

Van Wilson presented on the demonstration of integrating Medicare and Medicaid enrollees. HCPF two years ago received a \$1 million planning grant to come up with a plan for integrating the delivery systems of Medicare and Medicaid for clients who are eligible for both. The two programs have different rules, duplicative benefits and conflicting financial incentives which for years has led to wasted money and disjointed care for those who qualify for both programs.

The demonstration integrates and coordinates physical, behavioral and social health needs for Medicare-Medicaid clients. The initiative builds on the infrastructure, resources and provider network of the Accountable Care Collaborative (ACC) Program, which connects clients with providers, community and social services to help meet client needs. The goals of the demonstration are to: (1) improve care coordination; (2) improve client experience; (3) improve health outcomes for full Benefit Medicare-Medicaid enrollees; and (4) decrease costs associated with unnecessary and duplicative services.

Update: There has been a robust stakeholder engagement and planning process to come up with the plan. A subcommittee (composed of Regional Care Collaborative Organization (RCCO) contract managers, advocates, and dually eligible individuals) was established. A Memorandum of Understanding (MOU) was signed with CMS giving HCPF permission to start operationalizing portions of the demonstration.

By the end of May 2014 HCPF must prove to CMS that the system (involving the RCCOs that are providers) is ready to take on clients. The plan is to enroll 48,000 clients. Beginning July 1st each RCCO will be taking on 750 to 1,400 clients per month. The RCCOs will play a bigger role in the coordination of care for the clients who will each receive a designated care coordinator and they will be finding the gaps in service and making referrals in order to make the client experience more seamless.

Protocols have been established between RCCOs and care coordinators and domains of care. New mechanisms for forming relationships with other care groups and different quality measures are being used to measure affects of the demonstration. Training is being provided at the provider, care manager, and RCCO levels to improve care coordination for clients with a higher acuity and more cognitive disabilities

For the first time ever Medicare data is being opened up and given to states for this demonstration. Attributions will be based on a combined data set of Medicare and Medicaid claims history. A passive enrollment process will be used to notify clients. Clients will receive a letter in the mail that says they will be enrolled in 30 days unless they choose to opt out.

Super-Utilizer (SU) Report

Dustin Moyer presented a super-utilizer report. SUs refer to clients who are high users of Medicaid, specifically those that have over 6 emergency room (ER) visits in a year and over 30 prescriptions in a year. The National Governor's Association (NGA) research noticed a trend that a small subset of health care consumers account for a great percentage of health care costs. This research tries to understand why this occurs and remedy it by developing interventions that would empower clients to take control of their own costs and reduce utilization and improve health outcomes.

Colorado has established a stakeholder process that involves agencies outside of the traditional health care delivery systems (human services, public health, housing, economic security) realizing that there are other factors that affect health (ie. affordable housing).

HCPF focused on the 480,000 ACC client population and of that group 3,000 were categorized as SUs with the average age of the SU being 35. The average spending of ACC clients was \$3,000 per client/year and the spending for SUs was over \$25,100 per client/year.

RCCOs 4 and 5 have the highest use of ER visits. SUs have about 11 visits per year and ACC clients less than 1 visit per year. HCPF partnered with RCCO 4 (Pueblo) and 7 (El Paso) for testing. Interventions will be developed, it will be tested with the RCCO, the success or failure will be measured. Each RCCO will provide interventions for 30 to 60 clients at a time. Clients for the intervention will be selected through a monthly data pull and using a tool that will help select clients that will be responsive to the intervention.

The intervention finalization is still a work in progress. The Intervention will involve identifying client goals; measuring patient readiness; client perceived health and trust of the health care system; prescription drug review; single care plan; community care teams; home visits and time limited clients.

RCCOs will train care coordinators in May 2014 and the enrollment date for this project is June 1, 2014 and the hoped for results are (1) reduced ER visits, (2) Primary Care Medical Providers visit increase (3) review of prescription drugs for each client and (4) improved health for the client.

The meeting adjourned