



COLORADO

Department of Health Care
Policy & Financing

Minutes

State Medical Assistance & Services Advisory Council

303 E. 17th Ave., 7th floor conference rooms 7AB
Denver, CO 80203

May 27, 2014

6:00 P.M. – 7:55 P.M.

1. MEDICAL SERVICES BOARD MEMBERS

An Nguyen, (Chair)

Mark Thrun, MD (Vice Chair)

Jill Atkinson

Dan Scales

Kimberly Jackson

Steve Holloway

Ruth O'Brien

Blaine Olsen, MD

Janet Puglisi

Blair Wyles

2. 6:00 Call to Order

3. 6:02 Approval of the minutes from the April 22, 2015 meeting

4. 6:05 Patient and Family Centeredness Initiative

Carrie Cortiglio-

Working definition of Person and Family Centeredness: An approach that respects the values, individual preferences, strengths and differences. Focus on doing things with clients, not to or for them. This initiative got started two years ago when the Department asked the Colorado Health Foundation for a grant to bring the Institute for Patient and Family Centered Care for a two day site visit. They met with a large number of internal staff and different stakeholder groups in order to evaluate the Department's current person and family centeredness. IPSCC gave a detailed report of recommendations. We then took the recommendations and wrote a larger grant to CHF in order to implement the recommendations. We are the first public health insurer to take on this kind of project. We do not provide direct services or interact with clients in terms of service provision, but work through contracts. There was a challenge to take the idea of person and family centeredness and applying it outside the realm of direct service delivery. We wrote a goal-statement for the project, and it is to incorporate person centeredness into Department business practices, policies, and partnerships. We have used some of the grant to hire Civic Canopy to design and facilitate a process, creating internal, cultural change. With Civic Canopy's help, the Department has recruited and convened an advisory council, exclusively made up of clients and family members. There was the idea that this work would be an interactive process, led by the Department's Executive Team, so that there would be buy-in from the top leadership levels. We've devised a process that would work through both the ET and the Advisory Council and a group of about 30 Department Champions- staff from each

division who have come together to do the work of implementing this project. The Advisory Council has already convened as an ad-hoc focus group. It was a huge struggle to get a representative group of clients for feedback, from designing the Medicaid ID card, to redesigning the website. The internal Champions have had a couple meetings as well, honing in on the three or four metrics of success for this project.

Questions: Are clients with disabilities represented? A: It has been difficult to recruit but those with disabilities are definitely represented.

Q: What are some examples of the metrics so far? A: One metric is employee engagement- we need to be person-centered in our internal work and the way we interact with each other. Every person in the Department should be aware of how they ultimately impact the client. We are looking at a way to catalogue how many business practices and policies have been changed. We are looking at two metrics around client experience- adding a short survey to the end of calls from the customer service center, if we are communicating with members in a way that is understandable and in a format that is most convenient for them.

Q: Any thought about making that a requirement for contracts? A: Absolutely. We have talked about that a lot and will likely go back to the health foundations to ask for the phase 2 piece of this project, which is how to implement this value in our contracts and our provider's interactions with clients.

Q: How far down the road is that? A: We have a work plan for the next year when the grant expires. It's a matter of figuring out the right time and is estimated at 18-24 months.

Q: Is there a complaints dept? I have been pleasantly surprised when talking to HCPF in comparison to any other agency. A: There's a general Ombudsman- the complaint historically goes to the contract manager but we are moving away from that. We are having our call center gather and collate that information so it's more usable. We have a number of complaint processes so we want to drive the traffic to the call-center. Comment: Tapping into the source of complaints may be a good resource for this project.

Q: Are there thoughts about any other level of customers, like providers, or is this project focused on the end- client, patient and family? A: At this stage the focus will be on the client. The Division of Intellectual and Developmental Disabilities is at that phase of implementing this value into our contracts.

Q: Are you looking at providing education for providers about how to provide person-centered care and work with certain populations, especially intellectual and developmental disabilities? A: one of the goals of the ACC is training providers. That will be in the next phase we haven't even started gathering data as of yet.

Q: How were members chosen for the Advisory Council, and how do they interact with the department? A: We are only two meetings in. Recruitment was difficult, but our goal was to have a council that represented different populations, and also geographic representation. We created an application that was disseminated widely and aggressively- we did fall short on the geographic representation because of the time constraint. It is 6 or 7 half days facilitated by Civic Canopy. We did want to make a distinction between clients that also professionally function as advocates or lobbyists- we wanted the voice of clients who aren't active in that realm. We have a core project team who did the final selection. As far as interaction with the Department- the process is we bring executive summaries of each of the meetings to the next group, creating a feedback loop between the Advisory Council, the Executive Team and the Department



Champions- facilitated by Civic Canopy. In the late summer we plan to bring the Advisory Council and the Champions together for a group meeting. We have also put out the fall for virtual advisory members who can't travel or make the time commitment to do an ad-hoc review of materials. As we get going there will be more connections between the Department and the Council. They have been working on input for the new Medicaid card, and working with the communications for enrollment group.

5. 6:20 ACC Rebid

Kathryn Jantz- We currently have to re-procure contracts every 5 years. We did an extension of the regional care collaborative organization contracts and we plan to re-procure them so the new contracts are in place for July 2017. We are looking at many changes for the contracts and for Medicaid as a whole. We are going to do a very broad stakeholder engagement process. The ACC partnered with the Program Improvement Advisory Committee will have topic- specific stakeholder engagement. Right now they are working on the criteria for care coordination. The subject-matter specific meetings have begun, the most recent meeting was a few weeks ago and it focused on care coordination by sending out contract language and soliciting input on what that should look like in the future. We are hoping to post a calendar of meetings so people can engage where they are most interested. This will be on the website shortly, along with an email address which is open for thoughts and suggestions. A lot of the ideas that are coming both internally and from stakeholders may require additional federal support.

The first major decision made so far is to combine RCCO and behavioral health organizations into a single entity. There has been some confusions surrounding this so there are clarifications that need to be made: we will be conducting a procurement process for this new contract, and the organizations need to meet both expectations. National vendors have also been expressing interest in the program. We need stakeholders to help us determine the requirements for making one entity successful.

As part of creating a single entity we had to create an organization map. We decided to go with the RCCO map because we felt having more vendors in a region better offered the diversity we wanted, and allows for tailoring to the different communities in Colorado. We are going to go out to Larimer and Elbert County for stakeholder outreach for their ideas on the best solution. We have heard a lot of concerns from providers about being split across regions. We are thinking about options for limiting the administrative burden. One option is allowing providers to opt into a region and for their clients to follow them- so it still remains a fundamentally regional approach.

The final decisions that we announced are around payment- we are going to keep physical health predominantly fee-for-service, although we want to think about how we pay the regional entity, or the RCCO/BHO combination. We have evolved the RCCO payments quite a bit in the past few years in terms of incentive structures. We have also reduced payment to clients who are not attributed to a primary care medical provider for greater than 6 months. So we want to continue to think about strategies where we are really paying for value. As far as Behavioral health, we will keep it largely capitated. However, we did hear loud and clear that there are current challenges with the system. This may result in gaps in service around early intervention, for those with autism, intellectual and developmental disabilities, and chronic conditions. So we want to focus on how we can change the payment model to make it one that supports holistic, whole-person care.



6. 6:30 Benefits Collaborative

Kimberley Smith-

Benefits Coverage Standards- We are nearing the end of the standards that were inherited from 2011-12, there are two or three to go. We are currently talking about the Office Visits Benefit Coverage Standard. It is very similar to the In-Patient in Surgery Services Standard. This is unique because it was drafted when the idea of the Benefits Collaborative and Benefits Coverage Standards were still being formed, so it is light on the description of the amount, scope, and duration of medical services available to clients, and heavy on describing providers and their requirements. The next step will be a larger conversation around this, the in-patient services benefit coverage standard, and the out-patient services standard, and questioning whether we think the benefits coverage standard is the right vehicle for providing this type of information. It is going to exist in a library of benefit coverage standards but mostly describing the amount, scope and duration of medical services that are available to clients. There is an effort underway in the Department to increase the member on-boarding experience. One conversation around this is the creation of a new client handbook that clients would receive when they first get on Medicaid- as a potential alternative for delivering this information.

Question: In your vision, what is the difference between the out-patient standard and the office visits standard? A: They do overlap. They may need to merge.

Q: We in Public Health have advocated for laboratory testing for simple things like cholesterol, diabetes, or STD screening. Some of those tests are available over the counter. Yet it is impossible for some people to get, and it's helpful to have a provider who covers those. Often times those tests are provided by non-clinician providers. For example our RN's perform these screenings and it is harder to get reimbursed for them. There is a need in Public Health as we shift screenings away from expensive clinics into the community to figure out how to advocate for those to be covered services. And I am not sure how that fits into the Benefits Coverage Standards. A: With SB222, Pharmacists are being considered.

Q: But what about behavioral health counselors who may be social-workers and do HIV tests? It is beneficial to Medicaid recipients that they be screened. And only the 5% who test positive in Colorado will need to receive additional care. A: We need to think about breaking it up- reimbursing for the actual process vs. reimbursement of the provider interpretation. We would love to screen for a lot of things but we don't necessarily have the clinical authority to do the appropriate interpretation counseling. There is a malpractice concern.

Q: I wouldn't want it to devolve into a scope of practice discussion. Rather- if the status of provider under their scope of practice however that is defined is allowed to do the test is there a mechanism by which they could be reimbursed? A: If it is within the scope of practice we do in fact do that sometimes through the Benefits Collaborative process. For example we have a genetic testing benefits collaborative. Someone asked for genetic counseling but pointed out that there is no code for a genetic counselor in the system. So we found a way for them to file a claim and be reimbursed. Now this begs the question- do we create some sort of screenings benefits-collaborative where we have these types of conversations?

Comment: I don't think that it's HCPF's role to take on the scope of practice. Advocacy can be helpful, but it's more the reimbursement. Even when it falls within scope of practice of a home-care nurse, reimbursement isn't possible. It is a specific requirement of Medicaid that I perform extensive



medication consultations that I do that, but I am not able to bill for it. A: It is beyond the scope of our mandate to authorize writs through the benefits collaborative standard, but we can do is make provider eligible to provide a service and provide the opportunity for further discussion.

Q: When is the out-patient Benefits Collaborative going to be available? A: Hopefully next month.

Ending comments: When I read The Benefits Collaborative Standards I find it of very limited use. I'm interested to hear if when you read this if you found it of value, and if so, which sections? Your suggestions are helpful because that sounds like something that would be of more value. Also, I'd like to celebrate. This is a pretty long list and we have gotten through almost all of them. So we are actually starting to have a library- somewhere people can go to educate themselves on their specific benefits. We are getting to the point where I think we can really start pushing this website. In the next couple months I'll most likely be coming back to ask you folks to get the word out because we have only had about 100-150 clients give the website hits so far. We will also be able to have more informed conversations at that point.

7. 6:50 Legislative Updates

Zach Lynkiewicz-

We had a rather significant budget agenda and a rather small legislative agenda. Our budget is 8.6 billion dollars for this year. It will likely grow as we grow in caseload.

We had 2 Department bills. One was HB 1079 which failed. It was around expanding our teen pregnancy and dropout prevention program. It provided counseling to prevent unintended teen pregnancies and encourage teens to stay in school. It did not provide contraceptives but there was confusion between this and the LARC bill which also failed. It passed out of the House with a Republican sponsor but was assigned to a rather tough Committee in the Senate. It has a sunset on the program and we are evaluating what to do next. We will be back next year with more information on this.

HB 1186 did pass. It was to expand the Children with Autism Waiver. Currently the program serves children ages 0-6 years old. There is a waiting list with 320 kids on it and an enrollment cap. Kids wait on average two years to be taken off the list, when they are normally diagnosed at age two. They stay on the list until 4 or 5 years, and then because of the age cap only receive one or so years of services. That is rather ineffective for the client. Early intervention for kids with Autism produces better outcomes. The bill eliminates the enrollment cap, increases the limit to age 8, guarantees 3 years of services after the time of enrollment, increases the service cap per child, per year, and allows that service cap to fluctuate so we can give providers rate increases. We expect it to be signed within by the governor within the next month.

HB 1318- requires the Department to do two significant things with the Office of Community Living. First, it requires us to create a single stream-lined waiver for adult intellectual and developmental disability waivers. We currently have a fractured system where there is no waiting list for the less acute waiver, but there is a long waiting list for the more comprehensive waiver. So clients are being forced into picking a waiver that may not fit their needs just to get services. The bill also requires us to create a plan to deliver conflict-free case management and a reasonable timeline for



implementation of the plan in order to avoid the inherent conflict of interest with community centered boards. This plan will be submitted to the General Assembly in November.

SB 228 Creates a method for our rate- review process. There has been a lot of back and forth from the budget Committee around our targeted-rate increases. The bill requires the Department to review all of our rates at least once every five years. The bill creates an advisory group of 24 members of different provider types who will meet and discuss the rate-review cycle. We have to review 20% of the codes each year and present to the advisory group as well as the JBC what the first set of rates are. That advisory group and the Budget Committee have the ability to change what we review on a majority vote. Once that is done we will hire contractors to look at those rates and produce recommendations through the budget process. We are also doing a report that is due in November that requires us to review all of our codes and compare that to Medicare rates or private insurance. Private insurance rates can often be proprietary information so it can be difficult for providers to access for comparisons. Hopefully it will help us identify which rates we will review in that first cycle.

Comment: SB 228- the bill lists each provider type that is being accepted and the receiving body that is going to accept or deny those providers. If you are interested in participating.

Targeted rate increases- There is a .5% rate increase across the board for all eligible providers. Some of the big winners within the targeted rate increase are Home Health, Personal Care and Homemaker Services, Dentists, and Anesthesiologists. We are struggling with the process to equitably distribute available money. We have a limited budget so the Department committed to providing more objective data behind the provider-type rate increase suggestions.

Q: How are you going to get the private payer rates compared to the Medicare rates since they are proprietary? A: We are hiring contractors that can pull some of this research. 66% of our codes have a Medicare comparison. The other 33% don't have a comparison, and some of those that take a huge portion of our budget such as the home and community-based rates don't have a private insurance equivalent either. In those instances we are looking at states that have similar waiver services and asking what they pay. It's very complicated. Hopefully this ongoing 5 year process will provide a framework which we can improve on. Comment: I would point you to CIVHC- it is the repository in the state that is self-reported by the insurers and required by the governor. Reply: Their data is not complete.

8. 7:00 Provider Re-validation and Enrollment

Taren Cunningham- We have a couple upcoming changes that will be affecting our entire provider community. We are working on three different projects right now: The Commit Project, Revalidation and Screening, and Provider Enrollment. The Commit Project is the Colorado Medicaid Management Innovation and Transformation project. It is 3 separate health care enterprise systems the Department is looking to launch in November 2016. This includes the Colorado interchange, which is a new MMIS, a new Pharmacy benefits management system, and a business intelligence and data management system, which is a very advanced data aggregator that's going to revolutionize the way we are able to look at population management and data. The current MMIS is around 20-25 years old. This new one is by HP Enterprise Systems and they have successfully rolled this out in several states across the country. Some new features are electronic provider enrollment, there will be new provider portal for billing and remittances. We are going to electronic cars in the care and case management system to replace the bus, and online self-paced provider training. The online provider enrollment tool acts like



turbo tax for providers- you select your enrollment type and it adapts to the provider type so you don't have to go through all the unnecessary process while enrolling. We are bringing this tool up as a separate part of the new MMIS in September of this year. We are bringing it up so early because of the provider screening requirement which requires us to re-validate and screen our existing Medicaid and CHP+ providers. We will be using new screening requirements for new and existing providers going forward. CMS's reason for doing this is to reduce fraud, waste and misuse, so it is being done at a federal level. We have until March 31st of 2016 to re-validate all out 40,000-some providers. After this first re-validation cycle we are simply required to re-validate every 3-5 years depending on the provider type. Providers who traditionally enroll into an MCO or a BHO, as well as providers who order, prescribe and refer, will need to individually enroll into the new Colorado Interchange. The new screening requirements are risk-based. CMS divided providers up into three categories based on their risk of fraud or waste. The higher the risk, the higher the screening requirements will be. Limited risk goes through federal and state requirements, license verification, and getting run through the federal exclusion database checks. Moderate risk includes all screening for limited risk, as well as pre and post-enrollment on-site inspections. High risk includes everything that moderate risk goes through with the addition of background checks and finger printing for the providers. There is an entire list of our draft rule online of which risk category provider types will land in. For this first re-validation cycle we are required to screen all of our providers as if they were new. There is also now an application fee required by CMS only for institutional provider types such as hospitals or home-health agencies. It does not include individual practitioners. It also excludes anyone who has been screened in the past 12 months in a CHP+ or Medicaid program in another state doesn't have to pay the fee or go through the screening if the screening was passed and the screening requirements were just as stringent as in this state. And anyone is eligible to request a hardship waiver to waive the fee. The deadline for enrollment is March 31st 2016. We will be performing this in 7 waves, and we will notify providers which wave they are part of and how large their window is. In our new system a lot of providers will be required to have NPIs. A lot of confusion with this comes from wondering where to submit claims. We are not doing anything with the new interchange system until November 2016. So claims will continue to be submitted to the current system.

We have created a webpage for this with all of our FAQs, timelines and instructions. This is available at colorado.gov/hcpf/provider-resources. To find the provider-type risk category go to colorado.gov/hcpf/provider-implementations under Federal Provider Screening Regulations.

The Department is currently seeking a provider fee exemption waiver for the entire state. We can't guarantee this will happen since only one state has been successful so far.

9. 7:15 Crisis Stabilization

Abigail Tucker- Colorado Crisis Services- The state launched 3 RFPs for crisis services. The first went live in August 2014 and that was the Sate Crisis Line. The first provision was to have one consistent crisis line for the entire state that would serve as a confidential repository for all of the crisis services in the state. The second RFP contract was signed on September 1st 2014 and the services went live on December 1st of that year. All regional crisis centers use the same crisis line. They all have the same branding and all four providers will be coming to the table to share what services look like in consistent provider groups. The 3rd RFP was for marketing and awareness. That was awarded to Cactus,

Our mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.
www.colorado.gov/hcpf



and they did billboards across the state, a few public service announcements, and they put together the logo information. The service we are talking about is focused on Denver-metro services. Denver Metro is 6 mental health centers created under a distinct LLC called Crisis Connection. They launched 6 walking crisis-centers, 6 mobile crisis teams, 3 adult crisis stabilization units and 2 child crisis stabilization units. The walk-in crisis centers are really the brick and mortar of the behavioral health crisis services. They receive the most volume- we are open 24-7-365. Typically at the walking crisis center is also where the mobile crisis team is housed, so the crisis center can deploy all of the other services of the crisis team. If it is determined that you need an adult crisis stabilization unit, or a respite bed, or 23 hour observation, if it is determined that you need mobile crisis services, they are all available at the crisis centers. The mobile crisis teams are designed to meet crisis where it occurs. The walk in center is fully staffed at all times with an RN, licensed therapists, case managers, peer specialists, etc. Our two most common mobile crisis dispatches have been law-enforcement, and schools, where there are concerns with moving the child and avoiding escalation. Adult crisis stabilization units are designed to be 16 bed units. One of the balances after learning and growing was a new regulation where we had to do 5 distinct waivers and several other waivers dependent on site. Our two child crisis stabilization units are 8 beds each and they are 18 and under. They are running from 6-8 beds full on average. The respite services are sub-acute, so they are always unlocked facilities, usually in residential neighborhoods without an RN 24-7, but perhaps a therapist 24-7 for patients who might need monitoring but don't have a high or immanent risk. Those have been 100% full since open.

Q: so the mobile crisis units are located across the state? What is the average time for a mobile crisis unit to get to a situation? A: Every of the four providers should have the same- we have an 85-90% compliance rate with a one hour response time. Rural was given two hours. One of the ways rural centers manage that is that their mobile units work 100% from home, not only because it was hard to centralize but because it will also increase the response time.

Q: What level of training are the call-takers given? A: they have anywhere from high school to bachelor degree to masters level license. They are able to flex based on the call. All of them are trained on how to take quick information, and how to transfer the call from there. As far as information taking goes their training is much alike a dispatch unit.

Q: Are you keeping track of any data on how you are saving money by using these services? A: All of the vendors have strict targets and outcomes, and track them. For example 50% or more phone calls result in staying at the same level of care, preventing a higher level of care, or decreases the need for a crisis. The goal is not to have to dispatch law enforcement or go to hospitals. We are also tracking our outcomes on percentage of time that we made referrals, and percentage of time that we call within 72 hours of our last contact. In their 90-day startup the Community Crisis Connection created a separate electronic health record, so it made data collection much more fluent, and it helped bring down the regional boundary barriers, where all records were then accessible.

Q: Do you talk to other providers? Clients will tell us they utilized a mental health service but we are not given the information because it is confidential. A: We do follow HIPAA practices, but when it comes to crisis there is a lot more interpretation when it comes to who can we contact and inform about your services. I would agree that that is a barrier that needs constant attention.

Q: Where do most of your referrals come from? Private offices, self-referral? A: Our local services tend to be primarily law-enforcement and schools, however bed based services tend to come through our walk-in clinic. Some of them are coming from the provider clinics in the area.



Q: Are there any services provided that are less accessible to ADA patients? A: I do know that we will dispatch mobile services to homes of ADA clients but I do not know how routinely they are assessing the standards for providing care for persons with disabilities.

10. 7:35 Department Updates

Jeannette Jansson- The Department is working on the Governor's Bike Strategy. Our role is figuring out how to work with communities to make sure families have more active lifestyles- this is directly related to childhood obesity. We have been partnering with Livewell, the Bicycle Coalition, and a lot of organizations. We are not funding any of this. The governor has appointed Ken Gardener as Bike Czar. Children's hospital has a study going on with cycling and childhood obesity, so we have having conversations with them and targeting messages to help families use the preventative codes for nutrition counseling.

I am also currently working on the Well-Child project with Denver health and Children's Hospital to increase well-child checks in the state of Colorado. The current average is hovering around 55-60 percent for the last 5 years. We use the Bright Futures Schedule in Colorado .We also have a pay-for-performance for providers at ages 3-9 within the RCCO to increase those rates. This is a nurse lead project, and this is a public health, school-based nurses, and school based health centers are handing out information, and that is being coordinated by the Children's Steering Committee. That is open for participation.

There was a lot of talk about the targeted rate increases not being implemented in an appropriate amount of time last year. Some of those thing will be happening again this year because of the state-planned amendments that are required to implement some of the targeted rate increases. When the JBC passes the amendments they don't pass it with regard to how we have to implement it. We have an internal group working on that but there is going to be delay so please be aware of that. If you have questions we have a site that will be up for people to refer to. MMIS is antiquated and we can't operationalize some of the pieces. The pieces that go through the State Department will be delayed from CMS's approval, and our system also has problems with implementations to make it process correctly. They will definitely get paid, if not eventually.

11. 7:45 Round Robin

Round Robin was skipped for lack of time.

Reasonable accommodations will be provided upon request for persons with disabilities. Please notify the Board Coordinator at 303-866-6747 or hannah.tochtrop@state.co.us or the 504/ADA Coordinator hcpf504ada@state.co.us at least one week prior to the meeting to make arrangements.

