



Minutes

State Medical Assistance & Services Advisory Council

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

January 27th, 2016
6:00 P.M. – 7:45 P.M.

1. MEDICAL ASSISTANCE & SERVICES ADVISORY COUNCIL MEMBERS

An Nguyen, (Chair)	Penny Grande	Janet Puglisi
Dan Scales (Vice Chair)	Steve Holloway	Sarah Schumann
Jill Atkinson	Kimberley Jackson	Kenneth Soda
J. Scott Ellis, MD	Peter R. McNally, DO	Blair Wyles
Heather Gitchell	Ruth O'Brien	Judy Zerzan

2. 6:00 Call to Order

3. 6:02 Approval of the minutes from the August 26th, 2015 meeting

Minutes were approved without amendment.

4. 6:05 Legislative Update

David DeNovellis

The 2016 legislative session began on January 13th. The Department has 3 bills this session. SB 16-027 sponsored by Senator Martinez-Humenik and Representative Primavera allows Medicaid clients to get health maintenance medications through the mail, if that's the most convenient option for them. The current statute only allows mail-order prescriptions if clients have a physical hardship exemption. We believe that this bill will improve client convenience, help drug adherence, and reduce dispensing fees for the state because more people will get 90 day supply. This bill has been introduced, but not scheduled for a committee hearing. Kimberley Jackson offered that depending on the bill language, CCDC may be behind the bill and willing to send volunteers to testify.

HB16-1097 sponsored by Representative Coram and Senator Scott will reduce regulation for Medicaid transportation providers. NEMTs are currently regulated as common carriers, but access to licensure can be an issue. This bill would allow NMT and NEMTs to get a limited regulation solely for Medicaid transportation. This regulation would require providers to be licensed by the PUC, annual vehicle inspections, background checks and insurance. Providers would be required to annually re-apply for the license. We feel that this bill will be one step

toward addressing some of the Medicaid transportation issues- willing providers will be able to get their certification in a timely fashion, and it may encourage other providers to begin offering transportation. Ms. Jackson asked if this bill addresses accessible transportation requirements, and Mr. DeNovellis acknowledged that the bill does not outline and specific requirements since the bill is designed to be an initial step for smaller transportation providers to get their foot in the door. There will be other bills to follow that will address accessibility. This bill is scheduled for hearing in the House Transportation & Energy Committee.

HB16-1081 sponsored by Representative Ransom and Senator Lundberg is an efficient government bill. HCPF is required to submit 36 statutory reports, and due to changing circumstances, some are no longer relevant or go to the intent of statute when it was written. The Department is proposing repealing 7 annual reports and 2 one time reports that include information on non-existent programs, or are duplicative of other things HCPF publishes.

5. 6:20 Benefits Collaborative

Amanda Forsythe

A stakeholder meeting was held on the Vision Services Benefits Coverage Standard in October. The group was seeking input on their proposal to codify existing Department policy. Stakeholders included several members of the Optometrists Association, and were generally supportive. Based on feedback, HCPF plans to provide vision therapy services to children under 21 years of age, specifically orthoptic and pleoptic services for those diagnosed with convergence insufficiency. EPSDT may go beyond that for specific instances. There was additional feedback to add an annual eye exams for adults, not just when medically necessary. There is not a glasses benefit for adults at this time, only post-surgery glasses are offered. Before it is put into rule the benefit will be run past budget. Heather Gitchell, Representing Optometrists suggested that the benefits team consider including amblyopia treatment. Amblyopia can lead to monocular blindness or significantly decreased acuity in one eye. Treatment is widely considered effective and a considerable chunk of the population have this condition. Kimberley Jackson asked how the Department will enforce that providers who do not accept Medicaid do not bill Medicaid clients who visit their practices. Ms. Forsythe answered that if the provider doesn't accept Medicaid, it is their obligation to communicate that to the client. Anytime a client is wrongly billed, it is investigated by the Department. Ms. Jackson asked how this new benefit will be communicated to clients. Judy Zerzan answered that it will be helpful if the optometrist association is informed and can publicize it to all providers. The Colorado Optometric Association is working with HCPF to try to broaden those participating with Medicaid, and there has been a significant increase in providers in the past year. If anyone has additional questions, please feel free to relay them through Hannah. If you go onto the new Benefits Coverage website the FAQ document addresses questions that were asked at the stakeholder meeting in October (<https://www.colorado.gov/pacific/hcpf/benefits-collaborative-meetings>). Answers to some of the questions posed here tonight will be added to the page.

6. 6:35 UM Vendor

Michelle Miller

There have been mounting complaints about the vendor transition. The Colorado PAR program is the main UM vendor for the Department. HCPF contracts out five, one-year contracts. This contract was awarded on September 1st to EQ Health solutions. The contracting department at HCPF is responsible for the vendor selection process. One of the biggest obstacles during the vendor transition has been communication. The readership of provider bulletins is at a low. In June, HCPF attempted several avenues of communications such as email blasts, provider bulletins, At a Glance, stakeholder committees, etc. The results of communication attempts were not great. Another issue is that administrators are typically the ones submitting PARs, and

there was not a good trickle down of information from physicians to admins. The new system is the first time it has aligned the benefit coverage standards, rules and unit limitations within the PAR system. Additionally, HCPF was going through provider re-enrollment at the same time that the vendor transition came on. Providers who were still in the process of enrollment were stopped from submitting PARs. The biggest complaint and the biggest hurdle was regarding the ordering versus rendering provider's ability to submit the PAR. The claims system is set up so that the rendering provider is the one that submits the claim because they are the one who gets paid. This was a huge issue with transplants for example, where the ordering provider is the one who submits, and not the provider getting reimbursed. There was a complete system re-build with EQ Health to now allow all providers, regardless of rendering status. There were also multiple issues with modifiers, edits, unlit limitations, and getting the system to talk to MMIS, etc. The good news is the majority of these have been fixed.

EQ Health has an online proprietary PAR portal called EQ Suite. One of the good things about EQ Suite is that it can run reports. The whole design of this program is to be modern, and it needs to work for providers. Customer service is another major concern with UM that is being addressed. UM will be doing individual webinars based on category- one will be on DME for example. Any provider that wants one on one training will get it. If you know of provider groups that are struggling please let Ms. Miller know. There are also secret shoppers in long term home health that will let the Department know what their experience has been with UM. HCPF met with the RCCOs before go-live to explain the system and offer them a proactive teleconference. One goal over the next few years is to improve that initial communication. Michelle is trying to set up daily feeds to providers when their clients call the nurse advice line.

7. 7:00 SIM

Nicole King- Colorado SIM Office

The Colorado State Innovation Model, is an initiative of CMS that was started as a result of the Affordable Care Act. Colorado was initially awarded a \$2 million planning grant to advance health care innovation. Then the statewide plan was funded and we were granted a \$65 million award. Over 20 states have received SIM funding but Colorado is focused on improving the health of the state by providing access to integrated physical and behavioral health care services and coordinated systems with value-based payment structures for 80% of Colorado's residents by 2019. The SIM office is actually part of the Governor's office and the director, Vatsala Pathy, is part of the Governor's health care cabinet. However, she resigned last week and will only be with SIM through the end of February. The rest of the staff works out of HCPF, but sits at CDPHE. This is part of the initiative to integrate and ensure that this is a tri-agency initiative. SIM counts on the support of stakeholders across the entire state. At the foundational level they are engaging about 140 stakeholders who are subject matter experts across 8 different SIM workgroups that give advice and guidance to the SIM office. They also have an advisory board which consists of members of CDPHE, HCPF, the insurance commissioner, CDHS, as well as several community members.

SIM is taking a four-pillared approach in order to reach the goal of having 80% of Coloradoans with access to integrated care. 1. Payment reform is a huge driver towards change. SIM needs buy-in from both public and private payers to drive integration forward, ensure it is cost-effective, and that there is return on investment. 2. SIM will be supporting practices since there are up-front costs to integrating physical and behavioral health. 3. Population health is a huge piece of the plan. To achieve better health outcomes SIM is going out into communities and working with local LPHAs, as well as other public health leaders across the state to reduce stigma, increase awareness, and ensure people have access to services. 4. Health Information Technology is a critical piece. SIM will put systems in place to collect data in order to evaluate

progress and report back to practices. Across all of those 4 pillars SIM is making sure to engage consumers and making sure they are having a better experience. SIM is also working on policy issues such as 42 CFR part II in order to ensure that this project is feasible.

Colorado is the only state with SIM funding that has a robust multi-payer collaborative, including support of the private payers. Judy Zerzan serves as the chair of the SIM payment reform workgroup and works on the multi-payer collaborative. The payment reform plan is a four-fold categorization of different payment methods that comes from the Health Care Payment Learning and Action Network. Category number 1 is fee-for-service, with no link to quality or value. Number 2 is fee-for-service with a link to quality and value. Number 3 is an alternative payment model that's built on fee-for-service architecture but has some gains-sharing. And number 4 is a comprehensive population-based payment. CMS's goal with SIM and CPCI is to move from category 1, to ideally 3 or 4. Last week most of the payers in Colorado have signed on to a Memorandum of Understanding for SIM that they'll work with practices to move towards category 3 and 4 payment methods. This MOU outlined a commitment to align quality metrics and measures across the various payers, that they would share data, and take a common approach to accountability. Ken Soda asked if there will be any incentive for payers. Judy replied that each payer is trying to make providers more efficient, increase their costs, and improve the health of their population. If all payers are working toward the same goals, there is a lot more leverage to standardize care. The alignment of the payers will help practices get money from federal legislation because CMS has said they will favor places where payers are working in alignment.

SIM has adopted a framework among payers and practices based on the Bodenheimer Building Blocks of High-Performing Primary Care. There is a core set of 20-some measures that are the focus. The goal is to have at least 400 PCMPs participating in SIM by the end of the award period in 2019. The first cohort is currently being enrolled, so the first 100 practices will be announced two weeks from now. The approved practices will be matched with a practice transformation organization who will be providing them with a practice facilitator, as well as Clinical Health Information Technology Advisor (CHITA) that will help them move towards those building blocks. They'll do initial assessments of the practice to see how integrated care is at this point in time. All practices will participate in learning communities where they can share best practices and success stories. There will be provider education opportunities around this tied to CME credits and other incentives. Each practice will get a \$5,000 payment for participating. SIM also has a practice information fund available to each of these practices to apply for to further integrate care. SIM just received a \$3 million grant from the Colorado Health Foundation, and is working with HCPF to get a federal match on that, and there are some SIM funds already set aside. Long-term change will be sustained through savings brought about by these alternative payment models. In addition to Primary Care Practices, SIM is working with 4 community mental health centers to integrate primary care providers into the mental health center setting. Especially for individuals with persistent and severe mental illness, the community mental health center is their go-to source of care, and SIM wants to ensure there will be a primary care provider onsite to address their needs.

In terms of population health work, SIM is working with CDPHE and the Office of Behavioral Health to come up with provider education opportunities around integration. CDPHE has been working on three provider classes that have been identified as areas of high need: depression in men, obesity related depression, and pregnancy related depression. OBH will also be working on education including best practices in terms of prescribing psychotropic medications to children, as well as utilizing SBIRT. Additionally there was a funding opportunity for LPHAs: over half of the LPHAs in the state identified behavioral health and/or substance use disorders as a high priority in the community and SIM will be supporting work that addresses those disorders. There will also be two collaboratives of groups that don't have an LPHA at the heart of them but are working to address Behavioral Health in their community. That was run as a joint funding

opportunity with the Denver Foundation. SIM has now been able to provide funding to 35 counties across CO.

In terms of the HIT Strategy, SIM is looking to expand telehealth by working with the Colorado telehealth Network to expand broadband capacity to 300 sites across the state. SIM has already worked with 30 sites at this point to get that expanded broadband access. They have just contracted with Spark Policy Institute to formalize the telehealth strategy for the state. There is also an electronic data aggregator that will be coming to selected SIM practices that will combine all claims data from payers, and will include data on both clinical and behavioral health. This data aggregation tool can also be helpful for things like tracking clients when practices switch payers, as well as tracking integration progress. SIM is actively looking for input on how to engage providers with this ambitious project.

8. 7:30 Department Updates

Judy Zerzan

HCPF is continuing to work on ACC phase 2. The Department is working with stakeholders on how to operationalize the high-level terms of the concept paper. More information on that will be up on the website shortly.

SDAC- The Statewide Data Analytics Coordinator, which is the web portal for providers- is being re-procured, and will now be done through Truven. The Department is looking for ideas from providers as to what information would be useful to include on the portal.

9. 7:35 Round Robin

Kimberley Jackson- I have been doing provider education for working with people with disabilities. I have been to 9 different practices in 8 towns across the state. In 2016 we are hoping to develop an online provider training program to increase access.

Ken Soda- RCCO 6 is looking at designing and implementing programs for practice engagement and set-up programs for medical sub-specialty care access. This is being done in lieu of what RCCO 6 is seeing in the ACC 2.0 concept paper.

Steve Holloway- CDPHE's Colorado Health Service Core Provider Incentive Program submitted an application to Colorado Health Foundation a few months back for \$6 billion. This would develop better access for low-income populations in areas of the state that have poor access due to recruitment and retention challenges. We are also unveiling a clinician and registered health professional profiler system drawing data from multiple state systems, aggregating it, and providing better descriptive data about who is practicing what in the state. We have been working on this for about a year. It will be a resource for state-chartered business, research, and analytical functions between the University and CDPHE.

Janet Puglisi- Home Health care is having issues with the Medicaid reimbursement form. The form itself is complicated. Patients are not easily able to attend the required face-to-face visits, and physicians are not willing to provide their signatures.

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.