



COLORADO

Department of Health Care
Policy & Financing

MEETING SUMMARY 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

March 10th, 2016

1. Announcements

There were no announcements this month.

2. Approval of Minutes

Minutes were motioned for approval. Minutes were approved.

3. Consumer Input/ Client Experience

There were no issues presented this month.

4. PIAC Update

Todd Lessley: PIAC met last month and majority of the agenda was taken up with a discussion of ACC 2.0. We specifically discussed the timeline and payment methodology. Also discussed was the ER KPI. There weren't any significant updates from PIAC other than the updated ACC 2.0 timeline and the ER KPI. We did discuss the Access KP pilot, and an update on the state IT infrastructure and the BIDM, but otherwise there was not many updates.

5. Provider Revalidation Update

Marceil Case: The question hitting my desk most often is whether or not CMS has extended revalidation deadline until September 24th of this year. The answer is yes, they have. This has gone out in the provider bulletin and is public. The big caveat is that providers should not wait until September to enroll or revalidate. We are improving a lot of our processes, but it still takes a while to complete the process. I would recommend starting the process at least before Aug. 1st. The folks that are not enrolled yet have to be enrolled by Oct. 31st. It all takes time, so to make sure your payments are not impacted we need to make sure all providers are completely enrolled or revalidated. We are still getting a lot of questions from



providers who have not seen the resources on the website and elsewhere. Providers have told us that the training really helps and reading the directions really help. If you are able to do those things the application process should go pretty smoothly. We have additional staff being trained on the HP side. The Department is looking forward to having additional phone resources available in the next few weeks that people can call and get their questions answered in real time regarding revalidation. We've had more than 27,000 providers touch the system, but we've had a lot of providers who have yet to log on or even touch the system.

Anita Rich: Any role that we can play to help or messages you would like to give us?

Marceil Case: Share the information that the deadline has been extended. Let people know that payments will not be impacted in April. You can also let them know that we understand their frustration but that we really need to get this done.

Ken Soda: Are these individual providers or health systems that have to fill this out?

Marceil Case: We have facility enrollments, group applications, and individual applications. Anybody who is going to serve Medicaid members needs to go through the process. Anybody can do the work as long as they have the appropriate documents. Typically it would be the credentialing department if you are lucky enough to have one.

Todd Lessley: If you are a relatively new provider and are doing this for the first time, how long does it take from start to finish?

Marceil Case: If you had a perfectly clean application, it could still take 6 to 8 weeks. We can back-date enrollments and allow providers to see clients once they submit their applications, but it's not required, and I would recommend people wait until their application is completed before they start seeing Medicaid clients. The best thing I can tell people is to have all of their documents in order before they submit. Also note that it is important to follow the instructions.

Todd Lessley: You mentioned that HCPF doesn't have to pay claims that are submitted prior to the revalidation process being complete, but is that something that's worth submitting before we're revalidated?

Marceil Case: I cannot tell a provider in good faith that they can start seeing Medicaid clients and that we can back-date their enrollment even though that has been our policy in the past. The provider will have to sit on the claim until they have access to the portal to submit the claim.



Janet Rasmussen: We have had a little more difficulty with our BH providers. Have you had that kind of feedback? Anything that would make it more difficult for BH providers?

Marceil Case: Not reading the directions is a big issue we've been having with some providers. A lot of the errors we've had related to these providers has been related to not going through all the materials prior to filling out the application.

Janet Rasmussen: Is there a way to know which providers haven't even entered the system?

Marceil: We are able to get some of this information, but it is not necessarily complete. We also cannot sort the information by network or plan, so it will be up to RCCOs to know their provider's NPIs and IDs.

Nicole Konkoly: One thing we're finding is that if they don't get the enrollment type correctly they have to start over. Another thing is providers getting denial letters with blank reason for the denials. They were told they didn't correct their mistakes in a timely manner, so that has been very frustrating for them.

Marceil Case: Yeah the letters shouldn't go out with blank reasons, and we have had people denied erroneously within 60 days. We do have a grievance process which can be sent through that provider e-mail. The grievance process should be described online.

Todd Lessley: The provider bulletin – if we want to get somebody on that distribution list, how do we do that?

Marceil Case: I believe there is information at the bottom of the provider bulletin on how to do that.

6. COUP Letter

Kyle Huelsman: In general, we are moving forward quickly on the COUP lock-in program. We are clarifying roles with the RCCOs, and are finalizing all of the last pieces at the next RCCO Ops meeting. We are looking to have each RCCO do 20 clinical reviews, digging into the client's most recent claims history and really come out with a recommendation on whether or not the individual should be in the lock-in program. Ultimately we'll be relying on the RCCOs for that decision. On the criteria side, we talked about the focus on overdoses. We're still moving forward with our criteria, but we made a decision to default to the existing COUP criteria in the first round. Our focus at this point is getting the program launched and having all of the systems pieces in place. The existing criteria are: 16 or more drugs, 3 or more prescriptions in same category, 3 or more pharmacy, and 3 or more ED in the most



recent quarter. We're looking at moving on a MSB rule change on May 5th to change what we can do with the criteria.

Anita Rich: Is one of the criteria that they're over 18?

Kyle Huelsman: Right now we are pulling data on everyone but sending letters to only those who are over 18. Another question that came up last time was the piece around interactions with providers. We've made the decision to have the RCCOs first attempt to outreach the PCMP who they are attributed to see if they are willing to serve as the lock-in provider. We're also creating an MOU that the provider will be able to sign to clarify their role as a lock-in provider. We also took the letter to our client advisory board – based on that feedback we are re-drafting what the letter will look like. We want to focus the attention on driving the clients towards the RCCOs. We decided this because the RCCO will be the entity that will have the best understanding of the entire program and they can coordinate and get the client connected to the PCP. Any comments or questions?

Anita Rich: How does the client find out?

Kyle Huelsman: We're asking the RCCOs to reach out to the clients initially via a call, the clients will then receive a letter offering help from the RCCOs, and finally the lock-in letter.

Anita Rich: Do they have a right of repeal?

Kyle Huelsman: Yes, they will have a 30 day window to appeal.

Janet Rasmussen: When does the PCMP get notified?

Kyle Huelsman: Concurrent with the clinical reviews and once the decisions are made, the RCCO will begin outreaching PCMPs to find the appropriate lock-in provider, starting with the client's attributed PCMP if they have one.

Anita Rich: What if the client can't write their appeal? Is it in Spanish, too?

Kyle Huelsman: We are sending the standard appeals letter, we can look into this further.

Todd Lessley: Are there expectation or requirements around who will be doing the clinical review?

Kyle Huelsman: We're leaving it up to the RCCOs as far as who is doing the review according to our guidelines.

Todd Lessley: How will a PCMP understand what the requirements and expectations are around these folks?



Kyle Huelsman: We're drafting a fact sheet at this time, which will also be used as a recruiting tool. We will also provide an MOU template for the agreement between the RCCO and the lock-in provider.

Todd Lessley: What incentives are being put in place for providers to be a lock-in providers?

Kyle Huelsman: At this point we don't have any financial incentives, so we're really relying on the RCCOs and their relationships. Over time we'll have a better sense of who is willing to serve as the lock-in providers.

Janet Rasmussen: Are you outlining for delegated practices what their responsibilities will be and what the RCCOs responsibilities will be?

Anita Rich: If the provider the client is seeing does not want to be a lock-in provider, will you move this client's attribution without the knowledge of the client or provider?

Kyle Huelsman: Yes.

Ken Soda: What do you estimate the number of clients this will impact?

Kyle Huelsman: We are asking the RCCOs to do 20 clinical reviews, if we can get 100-200 folks locked in in the first round it will be a huge success. If we can get 500-600 in the 12 month period I think it will be a success. We have a lot of constraints, so we'll have a better understanding after the first round.

7. ER KPI Recommendation

Todd Lessley: What we have that's been distributed is the proposal to potentially change the ER KPI. At our last meeting we formulated these recommendations and we wanted to open it up for discussion. We didn't make our recommendation to the PIAC because we didn't feel as though we had consensus. The health Impact on Lives sub-committee is also looking at this KPI.

Josh Ewing: The feedback that we provided were specifically around bullet number 3. We suggested that we include all providers in that. And the final bullet around payment reform mechanisms and our comments were that if someone is showing up at the ER, the failure has already occurred. Sharing in savings and risk is therefore harmful to the hospitals because we have to serve these clients because of federal regulations. We've explored with our members what is going on around client education and we've found that some of this is already taking place and we are looking into this more. Anecdotally, what we're hearing is that they really are



working to educate all patients coming into the ED about where they can seek services.

Mandy Ashley: One of the main concern of our doctors had is that the best way to avoid ED utilization is primary care coordination. Also that "inappropriate" isn't the best terminology for ED utilization, but rather "potentially avoidable."

Janet Rasmussen: The issue is that primary care providers are trying really hard to educate and we feel like we're facing an environment where hospitals are putting up billboards advertising really short wait times for emergencies. One assumes that if it's an emergency someone is not looking at a billboard for a wait time.

Josh Ewing: I think there are broader conversations to be had around marketing. As a membership organization we will never dictate to our members on issues of business strategy, but the point is well taken. I think there are opportunities for us to work together.

Janet Rasmussen: And I agree that it is our job to expand our hours and give clients a more appropriate option for care.

Josh Ewing: And this is not to say that hospitals do not have a responsibility here and that we don't have a role to be played, but if the client is in our ED we have an obligation to treat them.

Anita Rich: What would CHA recommend? What is the hospitals responsibility around this piece of data? How do we pull in that piece of responsibility? Do you have suggestions on how that could be done?

Ken Soda: One of the systems St. Anthony's put in place was to direct clients to a PCP once they reached a certain level of triage. I don't agree that clients have to be treated by hospitals because of MTALA. They need to be assessed and stabilized, but not all clients need "treatment."

Shera Matthews: The new Medicaid handbook that is coming out doesn't mention one word about urgent care centers. We need to educate clients on these options as well.

Josh Ewing: The reason why I assume it's not mention in that handbook is that we don't have a definition of urgent care in Colorado.

Ken Soda: Even though there are urgent cares, it depends on the affiliation of the organization whether or not the visit is billed as an ED visit.

Anita Rich: Do we want to stay with these bullet points?



Ken Soda: I think we should take the recommendation of CHA that we include other providers.

Josh Ewing: We would just like to strike the 5th bullet. I would also note that the other sub-committee was given a presentation indicating that inappropriate ED utilization is actually going down. The question is whether or not these changes are actually necessary.

Susan Diamond: I have no objection to removing the final bullet. Payment reform is something we need to focus on down the road, but it still says what we want it to say.

Shera Matthews: On the nurse line, aren't they in the same boat as the ERs, don't they have to err on the side of ERs?

Brenda: Depending on the level of expertise, they would be able to get more information on the client's situation and be able to give a more informed opinion.

Next meeting 4/14/16.

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