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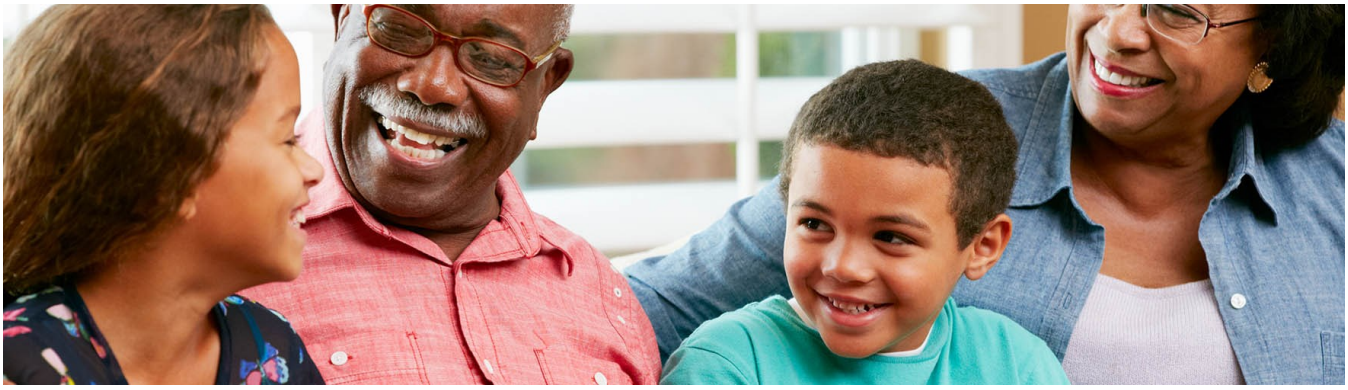
Community Health Partners



ICHP : Department of Health Care Policy & Financing Updates

Targeted Rate Increases Update

Targeted rate increases on certain high value services have taken effect on July 1, 2015. The fee schedule is being updated to reflect these increases; however, the new rates cannot be paid to providers until the Department receives federal approval from the Centers for Medicare and Medicaid Services (CMS). The Department is working to attain approval from CMS in order to implement the rates on July 1, 2015, but it is likely that implementation of some rates will be delayed beyond that date. Rate increases will be loaded into the MMIS within a few weeks after federal approval.

The Department will provide monthly updates on implementation of the Targeted Rate Increases.

Provider Revalidation and Enrollment

Section 6401 (a) of the Affordable Care Act requires that **all enrolled Medicaid and Medicare providers and suppliers** revalidate their enrollment information under new enrollment screening criteria.

Beginning in September 2015, all existing Medicaid providers will simultaneously undergo revalidation while enrolling into the Department's Colorado interChange system. All existing Colorado Medicaid and CHP+ providers must revalidate and enroll by **March 31, 2016.**

New Medicaid ID Cards Coming in July

Some changes are being made to Medicaid ID cards issued after July 1, 2015. New cards will look very similar to the current cards, but will be made out of sturdy paper stock and will no longer contain a magnetic strip.

Current Medicaid ID cards are still valid; Medicaid members do not need to request new cards.

As a reminder, Medicaid members are only required to furnish their photo ID at appointments. Medicaid ID cards are not required to receive services. Providers should verify member identity and eligibility at each appointment.

Accountable Care Collaborative Statewide Update

As of May 31, 2015, about 856,000 clients were enrolled in the ACC. ACC enrollment figures continue to increase by about 20,000 new members each month.

ICHP Client Enrollment as of July 1, 2015: 106,692

PUEBLO, COLORADO MAY 15th – Colorado State University- Pueblo Nursing Department and The Pueblo Early Childhood Council hosted its 5th annual Pueblo Community Baby Shower event at the Praise Assembly of God in May and ICHP was elated to participate in this important community outreach opportunity. The Pueblo Community Baby Shower is a free event for new and expectant mothers to equip themselves with knowledge necessary in raising happy, healthy, and safe kids. The community baby shower offers pregnant women and parents of children up to five years of age an opportunity to gain knowledge about the development, health, and growth of children.

Agencies throughout the Pueblo area including ICHP offered booths to help parents and families learn how to keep their children safe and healthy as well as how to access the services and tools necessary to help their children learn, grow and play to the best of their abilities. ICHP presented a booth with helpful information on navigating Medicaid benefits and gaining attribution to Provider Homes. In addition, ICHP provided informational tools for understanding and managing health concerns specific to young kids such as myths about immunizations, oral care for pediatrics, nutrition, childhood depression and the importance of getting Well Child Checks.

The event proved to be quite valuable to the ICHP team as it presented an opportunity to get out into the community we serve and speak to our members. The team was also glad to interact with many of the other community's providers. There were many experts in various aspects present including life coaches, education specialists, lactation nurses and pharmacists. These conversations gleaned valuable insights as well as challenges specific to our members and providers in the Pueblo area and has already inspired a number of initiatives specific to this population.

Nearly four million hospital admissions, roughly one in 10, could have been avoided if acute conditions or chronic diseases that resulted in hospitalization were prevented or better managed. Is there a risk-adjusted method for determining if a hospitalization could have been avoided? Using 3M™ Population-focused Preventables Software, potentially preventable admissions (PPAs) can be identified.

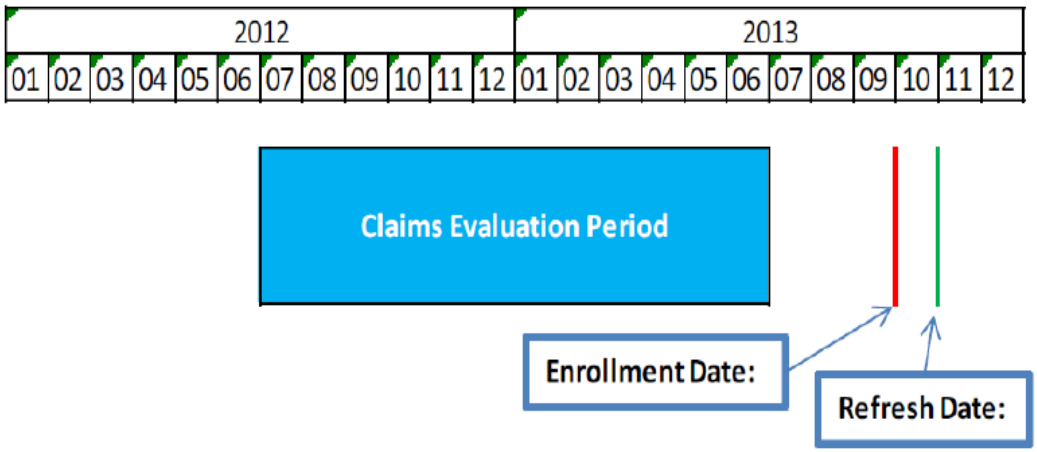
PPAs are facility admissions that may have resulted from the lack of adequate access to care or ambulatory care coordination. They are essentially ambulatory sensitive conditions (e.g., asthma) for which adequate patient monitoring and follow-up (e.g., medication management) can often avoid the need for admission. The occurrence of high rates of PPAs represents a failure of the ambulatory care provided to the patient.

PPAs are more comprehensive than the list of ambulatory care sensitive conditions as initially defined by the Agency for Healthcare Research Quality (AHRQ) in the 1980s. They are more comprehensive, in large part, because of: 1) advances in our understanding of the role coordinated care can play in avoiding admissions, and 2) better patient risk adjustment that expands the list of PPAs.

Identifying excess PPAs by comparing risk-adjusted rates of PPAs across providers allows a wider range of conditions to be identified as a PPA. Since a PPA rate can be influenced by the patient's chronic illness burden, comparisons of PPA rates are adjusted for the chronic illness burden of a patient. The PPA method uses 3M™ Clinical Risk Groups (CRGs) for risk stratification for comparing actual and expected PPA rates. Further, the mix and intensity of the services provided during the admission can vary—thus the PPA methodology uses the 3M™ All Patient Refined DRG (APR DRG) Classification System to quantify the intensity of the services provided during the admission.

A List of PPAs, Based on 3M APR DRGs
053 - Seizure
054 - Migraine & other headaches
113 - Infections of upper respiratory tract
137 - Major respiratory infections & inflammations
138 - Bronchiolitis & RSV pneumonia
139 - Other pneumonia
140 - Chronic obstructive pulmonary disease
141 – Asthma
191 - Cardiac catheterization w circ disord exc ischemic heart disease
192 - Cardiac catheterization for ischemic heart disease
194 - Heart failure
198 - Angina pectoris & coronary atherosclerosis
199 - Hypertension
203 - Chest pain
244 - Diverticulitis & diverticulosis
249 - Non-bacterial gastroenteritis, nausea & vomiting
251 - Abdominal pain
383 - Cellulitis & other bacterial skin infections
420 - Diabetes
422 - Hypovolemia & related electrolyte disorders
463 - Kidney & urinary tract infections
465 - Urinary stones & acquired upper urinary tract obstruction

Key Performance Indicator (KPI) for Colorado Medicaid's Accountable Care Collaborative: Medicare-Medicaid Program (Effective FY 2015)

Measure Title	MMP Emergency Room (ER) visits
Motivation	Visits to the emergency department (ED) are costly, and because some of them are potentially avoidable, some types of ED visits also may be indicative of poor care management, inadequate access to care, or poor choices on the part of beneficiaries. Billings and colleagues developed an algorithm to analyze ED visits and assign probabilities that each visit falls into several categories of appropriateness.
Active Enrollment	The client population included in the rate is restricted to clients having active enrollment on the last day of the most recent month through which 3M has processed data. This day typically falls approximately 90 days after the last day of the evaluation period. Example: If the Evaluation Period is July 2012 to June 2013, the Active Enrollment is the population enrolled as of 9/30/2013. The picture below visually represents the Active Enrollment and Evaluation Period for the rate published on the dashboard in November of 2013. Future monthly dashboard updates will follow the same pattern. Identification 
Identification	ER Visits are defined using the following revenue code and CPT 4 Combinations. Any outpatient emergency department claim that did not have an inpatient stay on the same date of service for the same client ID number, defined using the following revenue code and CPT4 combinations: Outpatient claims with claim type(s) C "OUTPATIENT" or O "MCARE UB04 PART B CROSSOVER" with one of the following revenue code(s): o 0450 "EMERG ROOM", o 0451 "EMTALA",

Identification	o 0452 "ER BEYOND EMTALA", o 0456 "URGENT CARE", o 459 "OTHER EMER ROOM", OR o 0981 "PROF FEES – EMERGENCY ROOM SVC" Professional claims with CPT4 codes between 99281 "ER DEPT VISIT EVALUATION AND MGMT" and 99285 "Emergency dept. visit" Professional claims with: o Place of Service = 23 "EMERGENCY ROOM HOSPITAL"; and o CPT4 codes between 10030 and 69979 **This measure will be reflected as PKPY (Per Thousand per Year) on the dashboard
Population Exclusions	Clients who are not enrolled in the ACC: Medicare-Medicaid Program (MMP) ER visits that result in an inpatient admission are excluded from the criteria. Inpatient claims are defined as claims with Category of Service Code (COS_CD) equal to 05 "INPATIENT HOSPITAL" or 10 "MENTAL HEALTH HOSPITAL". Professional claims having an urgent care place of service listed on the claim are excluded. Multiple claim lines in same claim meeting the criteria, or multiple claims on the same date meeting the criteria, will be counted as only one ER visit for that client on that day. Clients who were enrolled in any managed care plan for a period of time during the reporting period; Clients with less than three months of Medicaid eligibility; Clients who are defined as part of the Medicaid expansion population Clients in the Working Adults with Disabilities Buy-in Eligibility Type (031); and Clients in the Children with Disabilities Buy-in Eligibility Type (032). Medicaid expansion clients
Time Period	Rolling 12 months
Claims Run Out	90 days run out, 30 days processing
References and Measure Origin	This metric is based on ACC metric removing Medicaid Professional Claim types of "E" or "K". Based on HEDIS Also please refer to KPI White Paper State Fiscal Year 2015 for further details which is found on the COSDAC Website Home page.
Version Date	03/30/2015

***Please note that the White Paper on MMP ER visits is designated "Draft" and this is not a KPI that is being calculated yet. It has been included in the newsletter so our partners can get a sense of what will likely become a new KPI soon for the MMP population. Given that it is in draft form and is not being measured yet, it is subject to change. The White Paper for Potentially Preventable Admissions however, is not a draft, it is the final version and this is a KPI for the MMP population that is being measured in SDAC.

Diabetes Self-Management Education Coverage

Services for accredited Diabetes Self-Management Education (DSME) to Medicaid members under certain conditions is a covered benefit beginning on July 1, 2015. Two new procedure codes are being added to the benefits of Colorado Medicaid, G0108 (individual classes) and G0109 (group classes). Facilities providing diabetes self-management education can bill using revenue code 0942 and identify the appropriate procedure codes on the claim. Individual providers that render diabetes self-management education can bill the procedure codes.

This benefit provides the following:

Up to 10 hours of diabetes-related training within a consecutive 12-month period following the submission of the first claim for the benefit which includes:

One hour for either a group or individual assessment;
Nine hours for group-only diabetes education;
Up to 2 hours of follow-up training each year after the initial 12-month period;
The training can be performed in any combination of 30 minute increments

Eligibility

Client has a diagnosis of type 1, type 2, or gestational diabetes.

Diagnostic Criteria

According to national coding and diagnostic standards, diabetes is defined as a condition of abnormal blood glucose metabolism using the following diagnostic criteria:

- A1C $\geq$ 6.5% OR

Fasting glucose $\geq$ 126 mg/dL on two or more occasions OR

- Two-hour post glucose challenge $\geq$ 200 mg/dL on two or more occasions OR
- A random glucose test $\geq$ 200 mg/dL for a person with symptoms of uncontrolled diabetes (16).

NOTE: DSME and Medical Nutrition Therapy (MNT) cannot be billed on the same day. DSME and MNT are complementary services and cannot be billed on the same service date.

Accreditation

A healthcare provider or entity interested in obtaining Medicaid reimbursement for DSME must become an accredited program provider. There are two accrediting organizations recognized by CMS: the American Diabetes Association's Education Recognition Program (ERP) and the American Association of Diabetes Educators' Diabetes Education Accreditation Program (DEAP). Colorado Medicaid follows the CMS policy of requiring accreditation from one of these programs.

For further information about each of these organizations, please contact AADE or ADA directly at:

American Association of Diabetes Educators (AADE)
http://www.diabeteseducator.org
(800) 338-3633

American Diabetes Association (ADA)
http://www.diabetes.org
1-800-DIABETES

In Colorado, a number of programs are accredited and can be found at http://professional.diabetes.org/ERP_List.aspx (accredited by the ADA) and at http://www.diabeteseducator.org/ProfessionalResources/accred/Programs.html#Colorado (accredited by AADE).

Once a provider or entity achieves accreditation or recognition, Colorado Medicaid must be informed of the accreditation/recognition certificate from ADA or AADE for valid reimbursement. The accreditation/recognition certificate information must be submitted along with the Medicaid provider Identification and National Provider Identification Number (NPI) by completing the information at https://www.surveymonkey.com/s/DSMEinformation. Once this information is received, the provider or entity will be officially recognized by Medicaid to conduct a DSME program.

Medicaid Billing Detail

Initial education must be provided in a continuous 12-month period starting with the first date the DSME benefit is provided and is reflected on the claim. It is available to members who have not previously received any services billed under codes G0108 or G0109. In the initial year, the total number of hours billed cannot exceed 10 hours and must be delivered in no less than 30 minute increments. The member is eligible for one hour of individual training and nine hours in a group setting.

After the initial 12-month period, a maximum of 2 hours of follow-up education are available as either individual or group education.

To bill for DSME, a number of key elements must be in place. The beneficiary must have:

- A diabetes diagnosis
- A written referral for DSME, provided by a physician provider or qualified non-physician provider;

The DSME program must have:

- Accreditation from either AADE or ADA;
- A Medicaid provider who is able to bill;
- A program for maintaining documentation of the beneficiary's diabetes diagnosis in his or her medical record

FQHCs

In order to be reimbursed for the diabetes self-management education services, the program at an FQHC must be recognized by the AADE or ADA. If the program at the FQHC is recognized, they can include the costs of diabetes self-management in the cost report and generate an encounter when there is a face to face visit with a listed provider (diabetes educators are not listed as eligible to generate an encounter). Even if the visit does not include a provider type that can generate an encounter the costs associated with a recognized DSME program can be included in the calculations that determine reimbursement amount.

If the FHQC does not have a DSME program recognized by the AADE or ADA, the FQHC must refer the patient to a recognized DSME provider for reimbursed diabetes education.

Summary

The procedure codes for this newly covered service are HCPCS G0108 (30 minute units, 2 units per day) for each individual counseling and G0109 (30 minute units, 2 units per day) for group counseling. Medicaid members are only allowed 20 combined units of DSME per year (up to two combined units of G0108 and up to 18 combined units of G0109). Fee schedule reimbursement for the procedure codes are:

G0108 - $40.22

G0109 - $11.04.

For More Information:

If you need more information about accreditation, or have questions about setting up a DSME program, please contact either:

AADE: DEAP@aadenet.org or call 1-800.338.3633
ADA: ERP@diabetes.org or call 1-888-232-0822

If you have general questions, please contact Christine Fallabel at The Colorado Department of Health Care Policy and Financing at Christine.Fallabel@state.co.us or call 303-866-5186 or Kelly McCracken at The Colorado Department of Public Health and Environment at Kelly.McCracken@state.co.us or call 303-692-2512

Care Coordination Corner

The ICHP Care Coordinators are the most AMAZING people! As we continue working on the Service Coordination Plans (SCPs) for the Medicare-Medicaid Eligible Members, we are discovering some new, and often challenging, requests for assistance. Some of these requests include trash services, transportation, animal services and household items to make life easier for our Members. The ICHP Care Coordinators have been very creative in their quest for assistance for our Members.

And a huge thank-you to our Primary Care Providers as well! Your responsiveness to requests for information and assistance with the care coordination process has enhanced our ability to provide services to the ICHP Members.

In addition to the SCPs, the Care Coordinators are always working to find new resources for the ICHP Members. They have also been invited to participate in several local community projects such as clothing drives, food giveaways and farm stands. The feedback has been great and they are always willing to help.

Have you heard?

Section 6401 (a) of the Affordable Care Act requires that all enrolled Medicaid and Medicare providers and suppliers revalidate their enrollment information under new enrollment screening criteria. **All** existing Colorado Medicaid and CHP+ providers must undergo revalidation **prior to March 31, 2016**. Providers will revalidate using our new online provider enrollment tool beginning in **September of 2015**. By revalidating, providers will also be enrolling into the Colorado interChange, an updated Medicaid Management Information System (MMIS) launching in **November of 2016**.

New Global Prior Authorization Form

Effective July 1, 2015, a new Global Prior Authorization Form and criteria will be used. The form and criteria are posted on the Forms section of the Department's website. The form must be fully completed prior to review.

Tobacco Cessation

Effective July 1, 2015, the Department has made adjustments to the policy regarding Tobacco Cessation products. The changes are seen below in bold.

"Medicaid will cover only one (1) tobacco cessation product at one (1) time, **except in the case of the Nicotine Replacement Therapy (NRT) Patch and NRT gum/lozenge co-administration.**

Member must receive a prescription (provider must be a Medicaid enrolled provider) and a PAR (the Department), **except for the first fill of NRT gum/lozenge**."

INTEGRATED Community Health Partners

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Fax: 719-538-1433
E-mail: info@ichpcolorado.com

We're on the web:
www.ichpcolorado.com

ICHP is looking for community members and providers to serve on our Performance Advisory Committee or our Stakeholder Advisory Committee. These committees help us by offering feedback about the program and making suggestions for improvements. If you are a Medicaid Member, have a family member who is Medicaid eligible, work for an agency or a provider who serves Medicaid members, we want to hear from you.

To learn more about our Committees visit our website or call 855-959-7340.

Colorado PAR New Vendor Notification

eQHealth Solutions was selected by the Department of Health Care Policy and Financing to provide utilization management services for the ColoradoPAR Program beginning September 1, 2015. Together, eQHealth and HCPF will serve Medicaid members by focusing on and implementing the Department's mission to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

The current provider portal used to submit online PARs will be modernized to provide additional features and clarity for providers.

In the coming months, please look for additional information regarding this transition in Provider Bulletins, the current provider portal (CareWebQI), on ColoradoPAR.com, and on the Department's ColoradoPAR Program website. Additionally, face-to-face training, webinars, and provider outreach campaigns are planned.

New KPI's and metrics are beginning to appear on the SDAC Dashboard for the MMP population. At this time, only "Variance PPA Acute Admits PKPY" (Potentially Preventable Admits per Thousand per Year) is showing up on the MMP Dashboard screen. Under "Other Measures" the following have been added:

Variance IP Acute Admits PKPY
Variance MMP ER Visits PKPY
Variance PPV Visits PKPY
Variance from Expected (Medical Only)
30 Day Post Discharge Follow Up.

There has been discussion about adding Depression Screenings as a KPI to the MMP Dashboard, but it has not emerged yet.

ICHP'S first report for the new MMP KPI is available. Our "Variance PPA Acute Admits PKPY" is at 0.2%. That is out of 6,152 members for a denominator. You may want to go onto SDAC and click the drop down box at the top right of the Dashboard page and choose "COSDAC ACC: MMP Dashboard" and look at what your facility's variance is.

Please join us for our upcoming Practice Managers Meeting on July 29th. We will be meeting in Pueblo at **503 North Main St. Suite #202** to discuss State Medicaid, ACC: MMP and ICHP updates.
Please RSVP via email to jessicaprovost@valueoptions.com or by calling 719/538-1447 with the number of attendees.