INTEGRATED
Community Health Partners

ICHP: Department of Health Care Policy & Financing Updates

All Providers
Medicaid Provider Revalidation Update

Many Colorado Medicaid providers have not yet begun the Provider Revalidation process. Although the Centers for Medicare & Medicaid Services (CMS) has extended its deadline for states to complete provider revalidation, it is important that providers complete enrollment and/or revalidation as soon as possible. By completing the enrollment/revalidation process as soon as possible through the Online Provider Enrollment (OPE) tool, providers will not experience any delay in payment when the new enrollment and claims management system, Colorado interChange, launches on October 31, 2016. Starting on that date, claims and encounters submitted by providers who have not enrolled and/or revalidated will be denied.

Please do not begin the application before reviewing all of the training resources available online. An incorrect or incomplete application requires additional review, which may add weeks to the processing time. Enrollment and Revalidation Instructions are available online. Be sure to review the Information by Provider Type before you begin the online training, as it will help you select the correct training. The Provider Enrollment Manual also includes valuable information to help providers complete applications correctly.

Colorado Medicaid Enrollment and Revalidation Information Center

1-800-237-0757, option 5. Provider.Questions@state.co.us

Available Monday through Friday from 8:00 a.m. to 5:00 p.m.

Closed between 12:00 p.m. to 1:00 p.m.

Provider Address Reminder

The Department stresses the importance of having accurate information from providers regarding their addresses. The Medicaid Management Information System (MMIS) stores three addresses for each provider including Billing, Location, and Mail-To. All addresses should include the entire nine-digit zip code. Please visit **USPS.com** to verify your complete nine-digit code.

Providers have two methods to update their address:

1. Via **Web Portal**.
Additional information is available in the **MMIS Provider Data Maintenance User Guide**.

2. Via mail utilizing the **Provider Enrollment Update Form**.
Please contact **Xerox State Healthcare at 800-237-0757** with questions.

What is Payment Error Rate Measurement

The Payment Error Rate Measurement **(PERM)** is a federally mandated audit that occurs once every three (3) years. This audit reviews claim payments and eligibility determination decisions made for the Medicaid and Child Health Plan Plus (CHP+) programs to ensure accuracy and appropriate claim payment.

2016 PERM Cycle

CMS will randomly select a set number of paid or denied claims from October 1, 2015 to September 30, 2016 to review for Colorado's 2016 PERM audit cycle. Starting this summer, Chickasaw Nation Industries (CNI) Advantage, a CMS contractor, will request medical records from providers corresponding to those claims. Providers will have 75 calendar days to provide documentation to CNI Advantage. If initially submitted documentation is not sufficient, CNI Advantage will request additional documentation. Providers will have 15 calendar days to provide the additional documentation. If documentation is not provided or is insufficient, the provider's claim(s) will be considered in error, and the Department will recover the money associated with the claim from the provider. The Department will also investigate the reasons why the provider did not submit proper documentation.

The collection and review of protected health information (PHI) contained in medical records for payment review purposes is authorized by the U.S. Department of Health and Human Services by regulation 45 C.F.R. 164.512(d), as a disclosure authorized to carry out health oversight activities, pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA); CMS PERM Review Contractor activities are performed under this regulation.

Please email CMS at **PERMProviders@cms.hhs.gov** or contact **Matt.Ivy@state.co.us** or **303-866-2706** with PERM questions.

State Budget Signed
Impact on Provider Rates

Gov. Hickenlooper has signed the FY 2016-17 state budget. It does include an additional $20 million of funds for Medicaid core primary care services to offset the originally proposed rate cut. Actual reimbursement rates for specific codes will be forthcoming, but are expected to be in the neighborhood of 87% of Medicare. The $20 million will be allocated to newborn care, well visits, sick visits, immunization administration, and other services. We will continue to share more specific information regarding the fee schedules for specific codes as it becomes available.

SAVE THE DATE:

Practice Manager's Meeting

October 5th, 2016

ICHP Office

Location: 503 N. Main Street; Suite 202

Pueblo, CO 81003

OR

Conference Call/GoTo Meeting

866-565-1246

Passcode: 2322919

Postpartum Billing

Postpartum follow up is one of the Key Performance Indicators that HCPF (Health Care Policy and Finance) tracks across all regions in the state. Our region (ICHP Region 4) has two benchmarks to reach, the first at 82.5% and the second at 86%. The Quality staff at ICHP have recently discovered that providers are not always getting credit for the postpartum follow up visits they are performing. It appears that some appointments are not being counted due to incorrect billing. Please refer to the attached White Paper from HCPF for proper billing codes that will ensure the system picks up the claim.

Key Performance Indicator (KPI) for Colorado Medicaid's Accountable Care Collaborative (Effective FY 2016)

Measure Title	Postpartum Follow-Up Care
Motivation	Mothers on Medicaid now account for greater than 40% of all births in Colorado. It is important that we track the care that is being delivered to this population.
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.
Denominator	Clients will be counted in the denominator if they meet the following criteria: • All women with a global bill or hospital delivery DRG or delivery CPT codes: 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622 • Or ICD-9 Procedure Codes: 72.0, 72.1, 72.21, 72.29, 72.31, 72.39, 72.4, 72.51, 72.52, 72.53, 72.54, 72.6, 72.71, 72.79, 72.8, 72.9, 73.01, 73.09, 73.1, 73.21, 73.22, 73.3, 73.4, 73.51, 73.59, 73.6, 73.8, 73.91, 73.92, 73.93, 73.94, 73.99, 74.0, 74.1, 74.2, 74.3, 74.4, ~~74.91~~, 74.99 • Or ICD-10 Procedure Codes: (0Q820ZZ and 10E0XZZ bill together), (0Q823ZZ and 10E0XZZ bill together), (0Q824ZZ and 10E0XZZ bill together), (0Q830ZZ and 10E0XZZ bill together), (0Q833ZZ and 10E0XZZ bill together), (0Q834ZZ and 10E0XZZ bill together), 0U7C7ZZ, (0U7C7ZZ and 10E0XZZ bill together), 0W8NXZZ, (0W8NXZZ and 10D07Z3 bill together), (0W8NXZZ and 10D07Z4 bill together), (0W8NXZZ and 10D07Z5 bill together), (0W8NXZZ and 10D07Z6 bill together), 10900ZC, 10903ZC, 10904ZC, 10907ZA, 10907ZC, 10908ZA, 10908ZC, 10A00ZZ, 10A03ZZ, 10A04ZZ, 10A07ZZ, 10A08ZZ, 10D00Z0, 10D00Z1, 10D00Z2, 10D07Z3, 10D07Z4, 10D07Z5, 10D07Z6, 10D07Z7, 10D07Z8, 10E0XZZ, (10E0XZZ and 10S0XZZ bill together), 10J07ZZ, 10S07ZZ, 3E030VJ, 3E033VJ, 3E040VJ, 3E043VJ, 3E050VJ, 3E053VJ, 3E060VJ, 3E063VJ, 3E0DXGC, 3E0P7GC • Or DRG 370-375 • Or APR-DRG 540-542 and 560 Pregnancies not ending with a live birth are excluded from the denominator.
Numerator	Clients will be counted in the numerator if they meet the following criteria: • CPT codes: 59400, 59510, 59410, 59515, 59430, 59610, 59614, 59618, 59622 • Postpartum care that is delivered before the client is enrolled with the RCCO is also counted.

Population Exclusions	• Clients who are dually eligible or enrolled in the ACC: Medicare- Medicaid Program (MMP); • Clients who were enrolled in any managed care plan for more than 3 months during the reporting period; and • Clients with less than three months of Medicaid eligibility.
Time Period	Rolling 12 months
Claims Run Out	90 days run out, 30 days processing
References and Measure Origin	**Prenatal and postpartum care: Postpartum Care Rate (NQF 1517):** **HHS Agency -** Centers for Medicare & Medicaid Services (CMS) **Measure Steward -** National Committee for Quality Assurance (NCQA) **Topic or Condition** Health Services Administration - Access Reproductive Health - Pregnancy **Measure Domain-** Process **Care Setting -** Ambulatory/Office-based Care **Denominator** Deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year *Multiple Births: Women who had two separate deliveries (different dates of service) between November 6 of the year prior.* ***Numerator*** Timeliness of Prenatal Care: A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in the organization and the gaps in enrollment during the pregnancy. Postpartum Care: A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery. **Target Population Age -** Unspecified **Data Source -** Claims; Hybrid **Measure Maintenance –** Annually Please refer to KPI White paper State Fiscal Year 2015 on Dashboard for further details.
Version Date	09/15/2015 12/11/15 Edited exclusions based on new budgets

Accountable Care Collaborative Disability-Competent Care (DCC) Tool
Colorado Department of Health Care Policy and Financing

Over the next 20 years, Colorado's population of individuals over the age of 65 is expected to double. Accessing and using primary care is the first step in maintaining the health of this population and persons with disabilities. We must prepare our health care system to ensure all people, especially those who require unique accommodations, can access primary care services.
PCMPs who use this tool will identify ways to improve access to their clinic, learn about existing regulations, and become aware of the risks of remaining inaccessible. Improving accessibility is not only the smart thing to do, it is the right thing to do.

How does the assessment work?

The RCCO works with the PCMP to decide when and how the assessment will take place. The Communication Access (pillar 1) and Programmatic Access (pillar 2) parts of the assessment may be done over the phone. A site visit is necessary for the Physical Access (pillar 3) part of the assessment. If all three parts of the assessment are completed on site, it takes approximately two hours to complete the process.

Before the site visit, the PCMP decides who from their practice should attend. For example, a facilities manager may be the best person to answer questions about physical access, and a practice manager may be the best person to answer questions about programmatic and communication access.

What happens to the assessment results?

Once the assessment is complete, the RCCO and the PCMP review the results together and prioritize which issues and gaps are most important and feasible to address. RCCOs will also use the results to refer patients to clinics that accommodate unique accessibility needs. Assessment results will not be used for enforcing compliance or requiring mandatory action. Results will only be used for purposes of education and improvement.

Who created the tool?

The Disability-Competent Care Assessment Tool was developed by ACC staff at the Department of Health Care Policy and Financing, RCCO representatives from each region, providers and advocates. It is based on three existing tools: The CMS Disability-Competent Care Self-Assessment Tool, the California Physical Accessibility Review Survey (PARS) and the ADA Checklist for Readily Achievable Barrier Removal.

I would like my practice to do this assessment. What are the next steps?

Colorado is in need of physicians who will become leaders in primary care accessibility. If you are a PCMP and would like to join this important effort, please contact your Regional Care Collaborative Organization.

Robert Harasimowicz is your Accessibility Coordinator for RCCO 4.

We look forward to working with all PCMPs on this important statewide initiative; to serve all people of Colorado equally regardless of age, gender, physical or cognitive abilities.

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