Colorado Health Partnerships, LLC
AspenPointe ♦ SyCare ♦ West Slope Casa ♦ *ValueOptions*

CHP PROGRAM IMPROVEMENT ADVISORY COMMITTEE AGENDA

April 9, 2015

11:00 a.m. Call to Order: Best Western Vista Inn, Buena Vista, CO

GoToMeeting: https://www4.gotomeeting.com/join/559627095 **Call-in Number: 1-877-919-8755 PC 8342477**

I.	Welcome, Roll Call and Introductions	
II.	Approval of Agenda	
III.	Approval of Minutes – January 8, 2015	
IV.	Network Adequacy	Chelle Denman
	• Contract Amendment specific to Institute of Mental Disorder Hospitals	Arnold Salazar
V.	Expansion of Substance Use Benefit	Paul Baranek
VI.	Long-Term Supports and Services Update	Paul Baranek
VII.	No Wrong Door Initiative	Paul Baranek
VIII.	Next Steps: Ideas for further education or discussion, agenda items	
IX.	Planning for Next Meeting – Thursday July 9, 2015 GoToMeeting 11:00 a.m. – 2:00 p.m.	
X.	Adjournment	

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Colorado Health Partnerships, LLC
PROGRAM IMPROVEMENT ADVISORY COMMITTEE (PIAC) MINUTES
January 8, 2015

Call to Order: 11:00 am – GoToMeeting 1-877-919-8755

I. Welcome and Roll Call

Members Present: Arnold Salazar/CHP, Jim Horvat/AspenPointe, Marianne Hall/Spanish Peaks, Renee Brown/Gunnison County DHHS, and Scott Smith/NAMI/La Plata Youth Services **Non-Members:** Erica Arnold-Miller/Quality Management/VO, Haline Grublak/Office of Member and Family Affairs/VO, Paul Baranek/Education Coordinator/VO, Kathy Van Gieson/Exec. Asst./CHP, Tina McCrory/COO/CHP

II. Approval of Agenda

The agenda was approved without objection.

III. Approval of Minutes – October 2, 2014

The October 2, 2014 CHP PIAC Minutes were approved without objections.

IV. Follow Up to Care

Access to Care Standards – Erica Arnold-Miller presented the Medicaid Behavioral Health Contract Requirements. There are many types of requirements some of which include State Medicaid contract monitoring requirements.

- Access to Services Requirements
  - Routine Appointments-shall be available within (7) seven days of the request; no waiting lists for initial routine appointments. Provider is required to OFFER an appointment in this timeframe to meet the standards. If a specific therapist, program or condition (such as Spanish-speaking) is included in the request, the timeframe does not apply. Arnold commented on the challenges around requests for child psychiatrists with a national shortage of child psychiatrists. Scott Smith commented the local mental health center oftentimes will offer an initial or routine appointment at a crisis center which could cause an inconvenience for the member when they see a provider at the crisis center and then go back to the main center for treatment and have to meet a new therapist/case worker and give all their information again. The rapport oftentimes is not there and the member may feel moved around, not being heard or not being valued. **Arnold stated that access to crisis services when someone is in crisis is important but to use our crisis centers in order to meet the seven day access and inconvenience clients when having to go to two different appointments and ongoing treatment when they seek ongoing treatment is an inconvenience we should try to avoid at all cost.** Arnold will talk to Erica offline to see if we can look at quantifying Scott's concern.
  - Urgent Requests for Treatment
  - Emergency Services
- Follow Up to Care Requirements
  - Ongoing mental health and substance use disorder services
  - Outpatient follow-up appointments
  - Routine outpatient appointments following intake/initial assessment
- Access to Care-Erica reported the GeoAccess Mapping software looks at the zip codes for both the member and the provider measures from a center point of the member's zip code. Erica suggested at a future meeting the Provider Relations Director could present on the Network Adequacy information if the group was interested.

- CHP's Performance Range FY14-*Quarterly performance range: Standard is 100%, corrective action is required at 95%*
    - Routine Appts: 99.7 - 100%
    - Urgent Appts: 100%
    - Emergent Face to Face Evaluations: 99.1 – 99.6%
    - Call Stats for July-Sep 2014: 99.4% of 6814 calls received at the service center; were answered, on average, in 7.67 seconds.

Jim Horvat commented on a therapist that is not getting paid by VO and when asked, Jim indicated that it hasn't impacted his ability to access services and the provider has contacted provider relations. Paul Baranek stated that there are also standards around how long it takes to pay a provider. In response to Scott's comment earlier on when members have to see different providers during a service episode and having to present the same information to get the providers up to speed, Jim said that he has heard of people wanting to leave the mental health center to get a private provider (because of the turnover).

V. Reporting Requirement Deliverables

Integration – Paul reported the ACA (Affordable Care Act/Health Care Reform) as well as the State contract have a lot of requirements regarding trying to move toward an integrated care system. Integrated Care is a systematic attempt to coordinate general medical services with behavioral health services with the goal that there is no distinction between behavioral healthcare and medical healthcare. A State contract requirement is the use of the Vermont strategies to move the behavioral healthcare system for Medicaid into an integrated care system. CHP has an Integration Incentive Program that provides incentives for providers who have submitted proposals (proposals must meet certain criteria to qualify) for projects moving toward an integrated care system. One of the best ways to get to an integrated care system is to have behavioral healthcare services delivered in the same place as physical healthcare services.

Jim commented on an issue with not being able to get a certain prescription drug through the mental health center but is able to get it through his primary care provider. It was noted how integrated care can benefit folks due to the communication between the behavioral health and physical health providers.

Paul reported a committee, **M**entors for Integration, **I**nnovation and **N**ew **D**evelopment (MIND) was formed with leadership from some of the mental health centers in order for sharing of knowledge and experience through conferences and trainings. A seven day internet training was sponsored through the University of Massachusetts for around 150 behavioral healthcare providers in how to do behavioral healthcare in an integrated care setting. Another resource on the website are two instruments to measure how integrated you are currently delivering services and what you can do to advance as the next step (Vermont Integration Profile (VIP) and the (IPAT) Integrated Practice Assessment Tool).

Another system that delivers care to members that we are trying to integrate with is the Long Term Care system. Letters have been sent to the nursing and assisted living facilities in the area to invite them to participate in quarterly meetings to educate them on how to access behavioral healthcare services and get feedback on coordinating within the systems.

The Criminal Justice System has become one of the largest providers of behavioral health services in the country. As part of a contract requirement a Criminal Justice Services Coordinator has been hired who reaches out to jails and prisons. With a data sharing system in place (complies with HIPAA), information is shared regarding medications and discharge so that we can make sure they continue care after they leave the Criminal Justice System.

Child **P**sychiatric **A**ccess and **C**onsultation for **K**ids (CPACK) is a system free to pediatricians who can call to consult with a child psychiatrist to provide easier access to behavioral healthcare. Paul will forward the CPACK Program Coordinator contact information to Kathy to distribute to the PIAC.

Cultural Competency – A lot of the contract reporting requirements come under the domain of member information, the grievance process and access standards. The **C**ulturally and **L**inguistically **A**ppropriate **S**ervices **S**tandards (CLASS) is a set of fourteen (14) standards developed by the federal Office of Minority Health and are the national standards for cultural and linguistically appropriate services. Some of the standards relate to providing information to members in their preferred language and providing language assistance. One standard which is also a contract requirement (bi-annual assessment), is to do an organizational assessment for cultural competency.

VI. CHP Organizational Assessment for Cultural Competency

Haline Grublak reviewed the CHP Organizational Assessment for Cultural Competency Data which was completed by an executive team staff member from each Partner Mental Health Center.

Under Quality Monitoring and Improvement, low scores were noted in the areas of maintaining copies of minutes, recommendations, and accomplishments of its multicultural advisory committee as well as having a process for continually monitoring, evaluating, and rewarding the cultural competence of staff. The Quality Committee will be discussing the low scores and the issue that not all the partner organizations have a dedicated multi-cultural advisory committee. Arnold noted the challenges of measuring cultural competency because it is not something that can be quantified and you are left with satisfaction surveys or soft measures which isn't ideal.

Renee Brown commented on using a community development approach/multi-disciplinary collaboration within each of the communities and looking at it from a health equities framework in terms of language and cultural competency. There is a need for human resource development/professional development and recruitment so that each organization has an integrated and culturally competent staff and related service. Trust is an issue because of tight knit communities and that is another challenge.

Under Demographic Data Haline noted that when looking at a Medicaid population about 30% of the Medicaid members on their enrollment forms are not classifiable as they chose not to fill out that section of the form.

Arnold commented that there needs to be a cultural change to the organization where the organization embraces it from the Board down in order to have an impact on the members. Arnold suggested bringing up the issue at CHP board meetings with the mental health centers about how do you create a cultural change with the organization to embrace cultural competency as a general theme for the management and board leadership that will hopefully flow out to all the other parts of the organization.

Under Linguistic and Communication Support low scores were noted in the areas of persons answering the telephone, during and after-hours, able to communicate in the language of the callers as well as, signs regarding language assistance posted at key locations. Haline noted they will look into helping the centers look for cost effective ways to piggy back off the VO Call Center and posting signage is an easy fix. There were comments on having a competent and skilled person for translating language.

VII. Integration Update

This item was addressed under the Integration Reporting Requirement Deliverables.

VIII. General Feedback

The idea of the agenda items was to give the community members on the Committee a sense of what the requirements are, what CHP is responsible for reporting and how CHP is monitored. General comments and/or suggestions: Scott is glad the cultural competency conversation is happening as well as the integrated care and glad to be a part of it. Renee agreed and appreciates the opportunity. Renee is retiring in February and will have her potential successor contact Arnold or Kathy. Renee also offered her multi-cultural resource staff to join in the conversation. A future agenda item may be to bring in more focus on this topic and bring in outside resources.

IX. Other

Haline thanked the committee for respecting the places where people come from with this very diverse group. Arnold plans on working to increase the participation of the Committee. The Agenda will be sent out early to the Committee for input.

X. Next Meeting – Best Western Vista Inn, Buena Vista

The next meeting will be at the Best Western Vista Inn, Buena Vista on Thursday April 9, 2015 from 11:00 – 1:00 p.m.

Submitted by: 1.13.15

Kathy Van Gieson, Executive Assistant Date

ValueOptions Medicaid BHO
Network Development Plan FY 2015

Background

Colorado Health Partners (CHP) delegates BHO Provider Network responsibilities to ValueOptions. Overall the BHOs and ValueOptions seek to maximize network participation commensurate with the continued participation of our current network and the addition of new providers based on criteria contained in this network plan. Long term success of the Colorado Medicaid Community Behavioral Health Services Program requires the right mix and number of providers to serve the behavioral health needs of BHO members and their families. To accomplish this ValueOptions, in coordination with the partner BHOs, develops and updates a Network Plan annually which serves as a guide to network development activities through the fiscal year.

Overarching Network Development Goal

ValueOptions overall goal, as the BHO Provider Network Delegate, is to ensure network adequacy for the partner BHOs by closely monitoring the Colorado Medicaid network and recommending the addition of providers based on overall Network and specific BHO needs. ValueOptions continues to recruit providers who have demonstrated experience providing care using a patient-centered model, have a needed clinical specialty, cultural background, or licensure level, and meet criteria for participation in the network.

ValueOptions considers a network adequate when the network contains a sufficient number of providers at all licensure levels, clinical specialty, cultural background as noted in the ValueOptions policy Network Design and Access Standards.

Key Strategies

1. ValueOptions uses specific criteria, based on the Network Plan, to recruit providers who can deliver behavioral health and substance use services to BHO membership under the BHO contract.

2. ValueOptions maintains credentialing and recredentialing criteria, as required in the BHO contract and for NCQA compliance. Monitoring of the credentialing process, as indicated in the Network plan, is conducted on a monthly basis through the Local Credentialing Committee and BHO quarterly and annual reporting.

3. Recruitment of providers who have a needed specialty or clinical expertise, not currently available in the current BHO network, takes precedence in the Network Plan implementation.
4. The network is expanded considering member enrollment so as not to spread relatively small numbers of Members across many providers. The BHO expects to meet access through broad provider caseload standards per the ValueOptions policy. These standards include:

- .3/1000: MDs/members
- .6/1000: PhDs/members
- 1/1000: Masters/members
- Substance Use Disorder Providers
    - Ratio of staffing of Substance Use Providers will be monitored on a monthly basis and best practice staffing ratios will be implemented.

5. Access to the Provider Network is monitored through Access to Care Reports, Grievance Reports regarding access, Quality of Care Reports, any access to care outreach with providers, and provider disenrollment reports.

6. ValueOptions regularly reviews current provider fee schedules to align with the BHO market and any future recruitment strategies.

7. ValueOptions works to engage specialty provider groups and facilities as needed by BHO Membership. This may include specialties such as Intellectual Disabilities, Autism, Members with Traumatic Brain Injuries or other groups that provide behavioral health services in addition to their non-covered specialty.

8. The ValueOptions Director of Provider Relations implements, monitors, and updates annually the Provider Network Plan in order to prioritize, recruit and secure participation from practitioners and facilities. The Director is supported in network plan management by the BHOs with the assistance of the provider support team and Local Credentialing Committee. In addition the Director has in place an active recruitment process that includes strategic partners, such as bilingual providers and community stakeholders, to assist in addressing potential network deficiencies.

BHO Network Plan 2015

Based on provider network monitoring results and recommendations from the two BHO partners, the BHO Network Plan for FY ’15 is described below:

BHO Network Recruitment Criteria

Practitioners and facilities that meet more than one criterion are considered critical to the BHO network and are vigorously recruited in areas where the need exists. Typically, the more rural and frontier areas of the Statewide network have a greater recruitment need on many of these criterion.

1. Providers who align with primary care and are co-located in an integrated model.

2. Providers who demonstrate experience through documented training and/or employment related history in the following clinical specialty categories needed by one or both of the partner BHOs for FY ‘15:

    1. Psychological Testing

2. Neuropsychological Testing
3. Substance Use Disorders
4. Co-Occurring Disorders
5. Eating Disorders
6. Elderly or Geriatric
7. Behavioral Medicine
8. Treatment of covered behavioral health disorders in special populations (Autism, Developmental Disabilities, Traumatic Brain Injury, Chronic Physical Illness)
9. Child Welfare and Treatment Foster Care Competent
10. Assertive Community Treatment (ATC)

3. Providers who have 10 or more Single Case Agreements within a year's time.

4. Prescribing practitioners in all areas:
    1. APRN/APN
    2. NP
    3. MD/DO (Board Certified Child and Adult Psychiatrists)

5. Providers who are included in other networks and serve an extensive number of Medicaid members.
    1. CDHS Core Service Providers (In Rural and Frontier Areas or where the BHO has indicated a need)
    2. Medicare/Medicaid Providers
    3. Medicaid Fee for Service

6. Providers who can provide treatment in a foreign language, ASL, and/or, have specific cultural experience.

7. Providers located in the BHO services areas that are considered rural or frontier where there are few providers and distance to a provider is more than 30 miles or 30 minutes as per Health Care Policy and Financing standards.

Provider Network Monitoring Methods

It is ValueOptions policy to ensure that providers are accessible and available to Members, and that the provider network contains the specialties necessary to accommodate the needs of Members. ValueOptions monitors overall provider network patient load on our network using a comprehensive system for monitoring patient load and overall network capacity. Information resulting from these monitoring efforts will be analyzed by the Local Credentialing Committee (LCC), which ensures that the network is adequate. When inadequacy problems are identified, the LCC will initiate corrective actions to address them. It is through this committee that network challenges, as well as opportunities, will be addressed. Specific monitoring activities will include:

Patient Load Monitoring:

1. Geo mapping software and density reports are monitored to determine areas where Medicaid members live and where providers, if there are inadequate numbers or too many, may be overloaded or have too few members on their caseloads.

2. Shortages in specialties in evaluated with the annual needs assessment, including numbers, types and specialties of providers available to BHO membership statewide. This type of assessment helps to identify potential overload of patients for a provider, who may be in high demand, because of a specific need, for example, of the language the provider speaks. .

3. Quarterly network adequacy reports, including information on providers not accepting new members, helps identify a potential gap in providers.

4. Review and monitor provider caseload ratios, as available for specific licensure or credential, are within standards noted on page 2, #4 and providers are available to accept new Medicaid Members.

5. Because the Partner Mental Health Centers (PMHCs) are a primary Network provider, the Partner BHOs, with ValueOptions, intends to work with their PMHCs, in FY ’15, to identify, as possible, appropriate standards and procedures for their patient load monitoring.

Other Monitoring Activities:

6. An annual review of the BHOs QAPI program evaluation, in consultation with the BHO QI Directors, indicating provider access problems such as not meeting access-to-care standards, grievance data regarding accessibility, such as waiting lists, and client survey information regarding access issues.

7. Review of ADA compliance through provider report during credentialing and recredentialing and facility based site visits as required by NCQA. This review includes TTY and other communication methods as required. Providers receive education on available communication methods available through the BHO including the language line, interpreter services and TTY or Relay Colorado.

8. Maintain a listing of all 27-65 facilities and their network status to ensure ample coverage is available for the network when needs of members arise.

9. Ensure an adequate number of providers are available to serve members in assisted living facilities and nursing facilities by monitoring the number of providers who are contracted to provide PASRR Level II service and deliver care in assisted living and nursing home facilities.

This list of provider network monitoring methods is not meant to cover all network development activities, as some activities are initiated because of new areas of emphasis, such as a new benefit or new covered diagnosis.

Culturally Competent Provider Recruitment and Retention Strategy

In collaboration with the BHO Member and Family Affairs Directors, as part of the BHO Cultural Competency Plans, ValueOptions Director of Provider Relations reviews network adequacy annually regarding the availability of providers who meet or exceed the cultural needs of Medicaid members by:

1. Using an updated and accurate list, assess number of providers with expertise in key culturally based populations;
2. Determine number of members, by county, through the enrollment file, within the key population groups;
3. Determine any existing gaps by a comparison of need in #2 and availability, identified in #1, as well as reviewing findings in Member and Family Affairs surveys or through contacts/surveys with advocacy organization of key populations;

4. Implement recruitment or retention strategies such as:
    1. Emphasizing the recruitment of providers who represent the culture or key language that is prominent in the BHOs service areas.
    2. Premium is placed on providers who speak a language that has been identified as being the most prominent in our area (Spanish).
    3. Consider, with BHO CEOs fee schedules that include an increase for providers who provide treatment in other languages.
    4. Including specialized provider training on Cultural Competency annually.

The ValueOptions Director of Provider Relations will review and consider retention strategies for hard to fill gaps with BHO CEOs.

Training and Education

Throughout the year, BHO providers are supplied with resources to build and maintain their knowledge of BHO activities and other specialty trainings as needed. The BHO will maintain a training plan to support providers in current BHO initiative with the support of subject matter experts and provider relations staff. These training resources will include:

1. BHO Websites
2. Webinars
3. Face to Face Forums
4. Newsletters
5. Provider Handbook
6. On-site support; and
7. Clinical and Administrative Support Tools and Forms

A training plan is developed annually and includes BHO and other feedback from multiple sources on the training needs of the network. In FY 2015, Medicaid network providers will have access to training on the following topics:

- Child Welfare Competency Training
- Cultural Competency
- Trauma Informed Care
- Access to Care Standards
- CMHTA Training
- Member Transition (i.e. BHO to BHO or Levels of Care Transitions)
- Colorado Community Behavioral Health Services Program and Service to the Community
- Complaints, Grievances and Member Rights
- Medicaid Eligibility and the Application Process
- Connecting with your RCCO

Summary

This 2015 Provider network Plan includes initiatives that will promote the development of the current network, expansion of needed providers, and maintain the quality of services to all BHO Members. The partner BHOs and ValueOptions considers the 2015 plan to be a “working document” and anticipates that the development plan may change through the year in order to meet the needs of Medicaid members and providers in the region.

COLORADO HEALTH PARTNERSHIP

Density Report - March 31, 2015

Data Analytics

State	County	Membership Count	Total MDs/DOs (Distinct Count)	Advanced Nurse Practitioners (Distinct Count)	Physician Assistants (Distinct Count)	Target Met for Prescribers?	Number of additional Prescribers needed to meet compliance in the county?	Total Psychologist (Distinct Count)	Target Met for Psychologist's?	Number of additional Psychologist's needed to meet compliance in the county?	Total Masters Level (Distinct Count)	Target Met for Masters Level?	Number of additional Master's Level needed to meet compliance in the county?	Total MD Service Locations (Count of Service Locations)	Total Non MD Service Locations (Count of Service Locations)	Telemedicine Service Locations	Total Providers (D+E+F+I+L)
CO	ALAMOSA	6,644	0	0	0	No	2	2	No	2	28	Yes	0	1	5	2	30
CO	ARCHULETA	2,871	1	0	0	Yes	0	1	No	1	4	Yes	0	1	3	2	6
CO	BACA	1,140	0	2	0	Yes	0	0	No	1	3	Yes	0	0	1	2	5
CO	BENT	1,764	0	1	0	Yes	0	0	No	1	4	Yes	0	0	1	2	5
CO	CHAFFEE	3,695	1	1	0	Yes	0	0	No	2	14	Yes	0	0	7	3	16
CO	CONEJOS	3,442	0	0	0	No	1	0	No	2	2	No	1	0	3	0	2
CO	COSTILLA	1,655	0	0	0	No	0	0	No	1	1	No	1	0	1	2	1
CO	CROWLEY	1,293	0	1	0	Yes	0	0	No	1	3	Yes	0	0	1	0	4
CO	CUSTER	863	0	0	0	No	0	0	No	1	3	Yes	0	0	1	0	3
CO	DELTA	8,481	1	0	0	No	2	1	No	4	10	Yes	0	1	7	2	12
CO	DOLORES	527	0	0	0	No	0	0	No	0	0	No	1	0	0	0	0
CO	EAGLE	6,736	2	1	0	Yes	0	0	No	4	6	No	1	3	1	7	9
CO	EL PASO	148,996	23	3	7	No	12	20	No	69	180	Yes	0	17	80	2	233
CO	FREMONT	11,816	2	0	0	No	2	1	No	6	20	Yes	0	1	4	3	23
CO	GARFIELD	13,466	4	0	0	No	0	0	No	8	10	No	3	1	3	12	14
CO	GRAND	2,159	1	0	0	Yes	0	0	No	1	3	Yes	0	1	3	9	4
CO	GUNNISON	2,919	0	0	0	No	1	0	No	2	7	Yes	0	0	1	3	7
CO	HINSDALE	153	0	0	0	No	0	0	No	0	1	Yes	0	0	2	0	1
CO	HUERFANO	2,364	2	0	0	Yes	0	2	Yes	0	5	Yes	0	1	3	0	9
CO	JACKSON	300	0	0	0	No	0	0	No	0	1	Yes	0	0	1	5	1
CO	KIOWA	367	0	2	0	Yes	0	0	No	0	3	Yes	0	0	1	2	5
CO	LA PLATA	9,847	2	0	0	No	1	3	No	3	20	Yes	0	1	9	1	25
CO	LAKE	1,916	0	1	0	Yes	0	0	No	1	6	Yes	0	0	2	3	7
CO	LAS ANIMAS	4,803	2	0	0	Yes	0	2	No	1	6	Yes	0	1	4	0	10
CO	MESA	38,360	18	2	1	Yes	0	6	No	17	51	Yes	0	7	20	5	78
CO	MINERAL	138	0	0	0	No	0	0	No	0	0	No	0	0	0	0	0
CO	MOFFAT	3,428	0	0	0	No	1	1	No	1	4	Yes	0	0	3	10	5
CO	MONTEZUMA	8,311	1	0	0	No	1	3	No	2	4	No	4	1	2	1	8
CO	MONTROSE	11,687	2	0	0	No	2	1	No	6	20	Yes	0	1	5	6	23
CO	OTERO	7,429	1	1	1	Yes	0	1	No	3	11	Yes	0	1	4	2	15
CO	OURAY	759	0	0	0	No	0	0	No	0	0	No	1	0	0	0	0
CO	PARK	2,516	0	0	0	No	1	0	No	2	7	Yes	0	0	4	1	7
CO	PITKIN	1,201	0	0	0	No	0	0	No	1	8	Yes	0	0	2	3	8
CO	PROWERS	4,871	0	2	0	Yes	0	0	No	3	6	Yes	0	0	2	2	8
CO	PUEBLO	59,168	16	0	0	No	2	11	No	25	55	No	4	16	28	3	82
CO	RIO BLANCO	1,250	0	0	0	No	0	0	No	1	6	Yes	0	0	8	12	6
CO	RIO GRANDE	6,157	1	0	0	No	1	2	No	2	2	No	4	1	2	0	5
CO	ROUTT	3,592	3	1	0	Yes	0	2	No	0	10	Yes	0	2	5	6	16
CO	SAGUACHE	1,076	0	0	0	No	0	0	No	1	2	Yes	0	0	1	0	2
CO	SAN JUAN	144	0	0	0	No	0	1	Yes	0	0	No	0	0	1	0	1

COLORADO HEALTH PARTNERSHIP

Density Report - March 31, 2015

Data Analytics

State	County	Membership Count	Total MDs/DOs (Distinct Count)	Advanced Nurse Practitioners (Distinct Count)	Physician Assistants (Distinct Count)	Target Met for Prescribers?	Number of additional Prescribers needed to meet compliance in the county?	Total Psychologist (Distinct Count)	Target Met for Psychologist's?	Number of additional Psychologist's needed to meet compliance in the county?	Total Masters Level (Distinct Count)	Target Met for Masters Level?	Number of additional Master's Level needed to meet compliance in the county?	Total MD Service Locations (Count of Service Locations)	Total Non MD Service Locations (Count of Service Locations)	Telemedicine Service Locations	Total Providers (D+E+F+I+L)
CO	SAN MIGUEL	1,365	0	0	0	No	0	1	Yes	0	2	Yes	0	0	3	1	3
CO	SUMMIT	3,880	4	0	0	Yes	0	0	No	2	11	Yes	0	2	3	3	15
CO	TELLER	4,864	1	0	0	No	0	0	No	3	5	Yes	0	1	4	1	6
		398,413	**88**	**18**	**9**		**30**	**61**		**180**	**544**		**21**	**61**	**241**	**118**	**720**

Note: 3,336 COM members reside outside of the 43 county COM BHO.

AUTHORIZED SERVICES UPDATE

New Substance Use Disorder Covered Service

NEW PASS THROUGH SERVICES

- Beginning on 4/1/15, we will no longer require authorizations for claims to pay for these services from in network providers:
  - Psychotherapy 30, 45 or 60 minutes
  - Family therapy with or without patient present

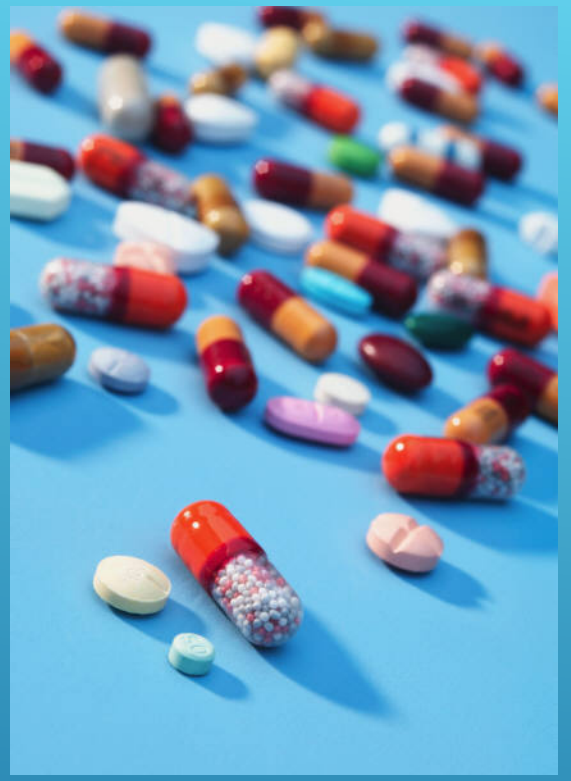
SUBSTANCE USE DISORDER (SUD) SERVICES

- New Benefit as of 1-1-2014
- Mental Health Versus Behavioral Health
- New Expansion of SUD Benefit

SOCIAL DETOX SERVICES

MEDICATION ASSISTED TREATMENT

- Using Methadone Only



OUTPATIENT THERAPY FOR SUD

- Outpatient therapy authorizations are effective for 6 months (180 days)
- May include assessment, individual therapy, group therapy, case management, peer support, drug screening *

*Collection and Counselling- not lab work itself

NEW SUD SERVICE ADDED!

- Intensive Outpatient Treatment
  - A structured substance abuse treatment program focusing on assisting clients to develop skills to regain stability in their lives and to build a foundation based upon recovery
  - Services provided to a client that last three or more hours per day for three or more days per week. A minimum of 9 treatment hours per week must be provided (6 hours per week for adolescents).

QUESTIONS?

Long Term Services and Supports (LTSS)

What Are They?

- Sometimes called long term care
- **LTSS**: A broad range of supportive services needed by people who have limitations in their ability to perform daily activities because of a physical, cognitive, or mental disability or condition. Most long-term care is not medical care, but rather assistance with the basic personal tasks of everyday life, sometimes called Activities of Daily Living (ADLs)
- The Medicaid program allows for the coverage of Long Term Care Services through several vehicles and over a continuum of settings. This includes Institutional Care and Home and Community Based Long Term Services and Supports.*

*from Medicaid.gov

Why Are They Important to Colorado Health Partnerships?

- Disproportionate Medicaid Spending on a Small Percent of Beneficiaries (FY 2012-33.8% of total Medicaid spending in Colorado)
- Contract requirements
- Good Care: Triple Aim- Better Health Care, Lower Cost, Better Patient Experience of Care
- Colorado's growth in its 65 plus population between 2000 and 2010 was 4th fastest in the US.*
- Between 2010 and 2020 Colorado's 65+ population is forecast to increase by 61%

*DOLA Report- Aging in Colorado

How Much Nationally?

- Total Medicaid LTSS spending was $140 billion in FFY 2012
- In 2012, spending for these services was $219.9 billion (9.3 percent of all U.S. personal health care spending), almost two-thirds of which was paid by the federal state Medicaid program.*
- 34.1 percent of all Medicaid spending
- Medicaid is the largest payer of long-term services and supports (LTSS), which includes home and community-based services (HCBS)

*National Health Policy Forum March 2014

More National Statistics

- By 2050, one-fifth of the total U.S. population will be elderly (that is, 65 or older), up from 12 percent in 2000 and 8 percent in 1950. The number of people age 85 or older will grow the fastest over the next few decades, constituting 4 percent of the population by 2050, or 10 times its share in 1950.
- About 11 million adults age 18 and older, almost 5 percent of the total U.S. adult population, receive LTSS. Of those 18 and older, the majority of adults receiving LTSS are 65 years and older (57 percent), but a substantial proportion are adults between the ages of 18 and 64 (43 percent) The risk of needing LTSS increases with age. (National Health Policy Forum March 2014)

Contract Requirements

"The Contractor shall provide outreach, a delivery system and support to nursing facilities and assisted living residences in its service area to determine the best approach to serving their Medicaid residents"

"The Contractor shall establish an ongoing quarterly meeting with all nursing facilities and assisted living residences in its region to address outstanding issues, Member concerns and any other issues that arise in the delivery of behavioral health services to nursing facility and assisted living Members."

Some Key Concepts

- **Activities of Daily Living (ADLs):** Personal assistance, such as help with bathing, dressing, toileting and eating.
- **Instrumental Activities of Daily Living (IADLs)**: Shopping, housekeeping, paying bills.
- **Home and Community Based Services (HCBS):** Home and community-based services provide opportunities for Medicaid beneficiaries to receive services in their own home or community. These programs serve a variety of targeted populations groups, such as people with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities.

Key Concept: Waivers

- **Waivers:** The mechanisms allowing Colorado Medicaid to provide supportive services to people with disabilities in the least restrictive settings possible, such as at home instead of a nursing facility. Some waivers have an enrollment limit, and there may be a waiting list for particular waiver.
- Colorado has more Medicaid waivers than any other state
- Community Mental Health Supports (CMHS) Waiver

Key Concepts: PASRR

- Preadmission Screening and Resident Review (PASRR):The PASRR process requires that all applicants to Medicaid-certified Nursing Facilities be given a preliminary assessment to determine whether they *might* have MI or MR. This is called a "Level I screen." Those individuals who test positive at Level I are then evaluated in depth, called "Level II" PASRR. The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care.

Contract Requirement

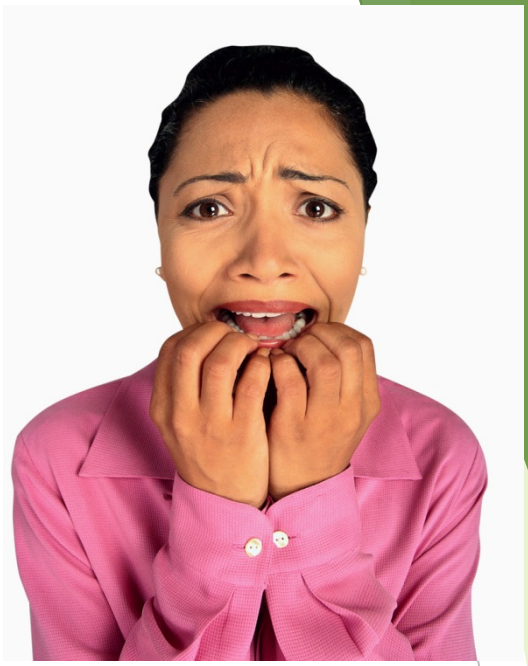
- The Contractor shall provide Pre-Admission and Resident Review (PASRR) Level II requirements and services to Members entering nursing facilities.

- The Contractor shall provide any specialized services identified on the PASRR Level II assessment that are covered behavioral health services

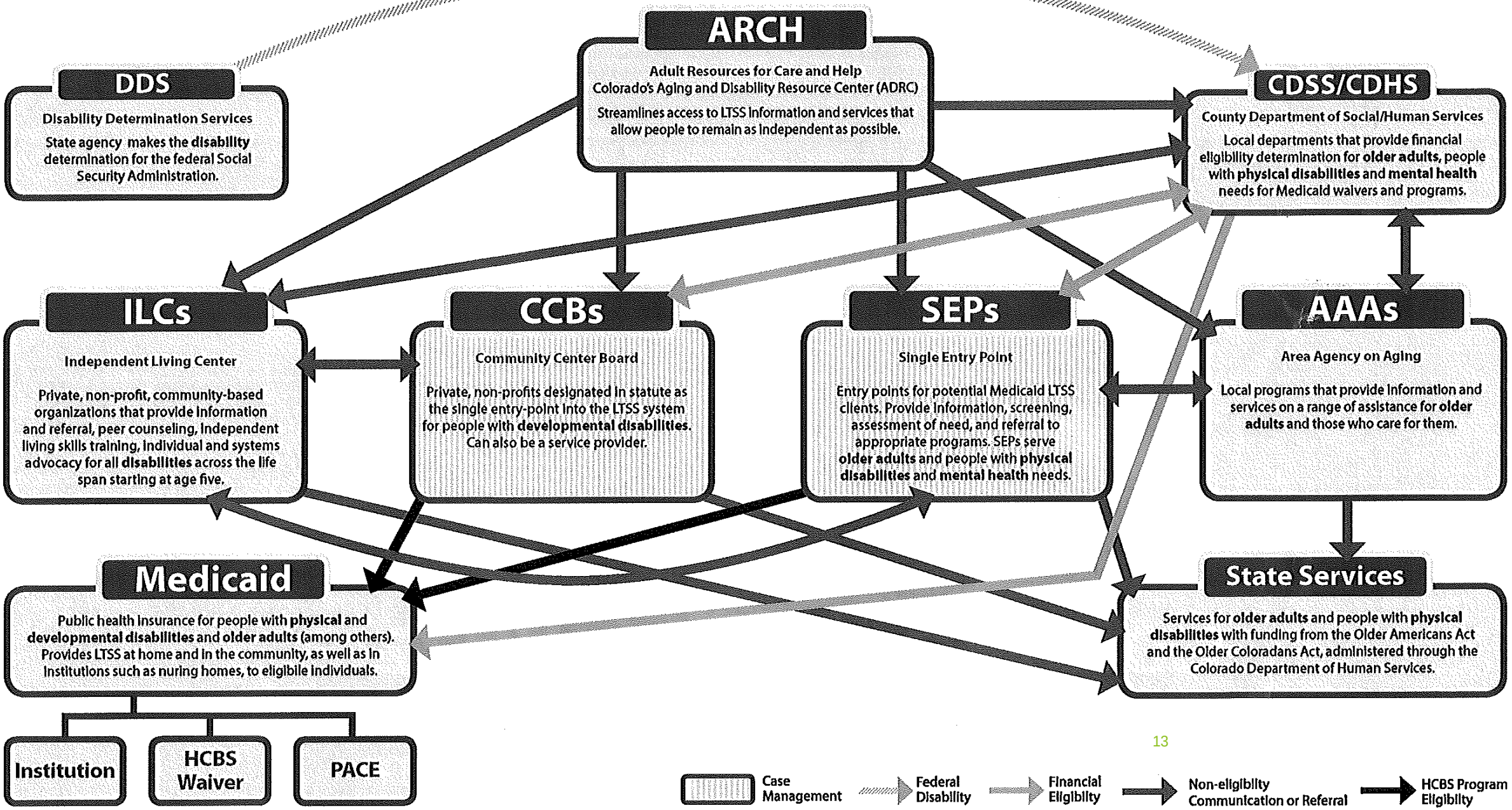
Key Concepts: The Olmstead Decision

- Supreme Court 1999
- Unnecessary segregation due to disability violates ADA
- Lack of support services not an excuse

Warning!



- The Following slide may cause confusion, headaches and dizziness


ARCH
Adult Resources for Care and Help
Colorado's Aging and Disability Resource Center (ADRC)
Streamlines access to LTSS information and services that allow people to remain as independent as possible.
DDS
Disability Determination Services
State agency makes the disability determination for the federal Social Security Administration.
CDSS/CDHS
County Department of Social/Human Services
Local departments that provide financial eligibility determination for older adults, people with physical disabilities and mental health needs for Medicaid waivers and programs.
ILCs
Independent Living Center
Private, non-profit, community-based organizations that provide information and referral, peer counseling, independent living skills training, individual and systems advocacy for all disabilities across the life span starting at age five.
CCBs
Community Center Board
Private, non-profits designated in statute as the single entry-point into the LTSS system for people with developmental disabilities. Can also be a service provider.
SEPs
Single Entry Point
Entry points for potential Medicaid LTSS clients. Provide information, screening, assessment of need, and referral to appropriate programs. SEPs serve older adults and people with physical disabilities and mental health needs.
AAAs
Area Agency on Aging
Local programs that provide information and services on a range of assistance for older adults and those who care for them.
Medicaid
Public health insurance for people with physical and developmental disabilities and older adults (among others). Provides LTSS at home and in the community, as well as in institutions such as nuring homes, to eligible individuals.
State Services
Services for older adults and people with physical disabilities with funding from the Older Americans Act and the Older Coloradans Act, administered through the Colorado Department of Human Services.
Institution
HCBS Waiver
PACE
Case Management
Federal Disability
Financial Eligibility
Non-eligibility Communication or Referral
HCBS Program Eligibility

CHP Involvement

- Community Living Advisory Group
  - Subcommittees: Entry Point/Eligibility; Care Coordination; Waiver Simplification; Consumer Direction
- No Wrong Door Planning Advisory Group
- Colorado Coalition for Senior Behavioral Health and Wellness
- Assisted Care Facility (ACF) Training Development Group
- Rules Rewrite and Katie Beckett Workgroups (Waivers)
- Quarterly Meeting with ACF and Nursing Home Stakeholders

Questions and Comments